

DOCUMENT RESUME

ED 425 857

PS 027 230

AUTHOR Price, Amy; Barth, Richard P.
TITLE Shared Family Care Program Guidelines.
INSTITUTION California Univ., Berkeley. School of Social Welfare.
SPONS AGENCY Children's Bureau (DHHS/OHS), Washington, DC.; Zellerbach
Family Fund, San Francisco, CA.
PUB DATE 1996-00-00
NOTE 136p.
PUB TYPE Reports - Descriptive (141)
EDRS PRICE MF01/PC06 Plus Postage.
DESCRIPTORS *At Risk Persons; Child Welfare; Community Programs; *Family
Programs; *Foster Care; Foster Family; Private Agencies;
State Agencies
IDENTIFIERS *Family Resource and Support Programs; Placement (Foster
Care); *Shared Family Care

ABSTRACT

Shared family care has been defined as the planned provision of out-of-home care to parents and their children so that the parents, supported by the host caregiver, cares for the child and works toward independent in-house care; this approach is an alternative to the trauma of separation and lack of continuity inherent to foster care placement. This manual details guidelines prepared for use by state and local public organizations and private community-based agencies that wish to incorporate shared family care into their standard continuum of services available for high-risk families. The manual was designed to educate interested groups in the potential uses of shared family care as a service option, and to identify the steps and information needed to initiate development and implementation of this service. The manual, comprising seven major components, allows for customization to specific situations. The components are: (1) an overview of shared family care; (2) guiding principles and anticipated benefits; (3) program elements; (4) host families; (5) licensing and liability issues; (6) financial considerations; and (7) program planning and evaluation. Materials in the manual's appendices include: sample forms and program materials; discussion points for legislators and administrators with estimated program cost comparisons; and a list of possible evaluation and assessment instruments. (LBT)

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Shared Family Care

PROGRAM GUIDELINES

AMY PRICE
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Acknowledgements

The *Shared Family Care Program Guidelines* were developed by the National Abandoned Infants Assistance (AIA) Resource Center, of the Family Welfare Research Group, School of Social Welfare at the University of California at Berkeley, with suggestions, information and assistance from the Shared Family Care Technical Expert Group.

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This manual was made possible by grants from the U.S. Department of Health and Human Services' Children's Bureau and the Zellerbach Family Fund. We especially appreciate the support and encouragement of Ellen Walker, Program Executive at Zellerbach. Special thanks also go to Jean Cornish, Janet Keyser, Sheila Merry and Sven Hessle for demonstrating that whole family placement can be implemented, and for sharing their expertise, experiences and program materials. The final responsibility for the content, veracity and value of the document is, of course, ours.

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This report should be cited as: Price, A. & Barth, R.P. (1996). *Shared Family Care Program Guidelines*. Berkeley, CA: Abandoned Infants Assistance Resource Center, School of Social Welfare, University of California at Berkeley.

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Preface

These guidelines have been prepared for use by state and local public organizations and private community-based agencies that want to incorporate "shared family care" into their standard continuum of services available for high-risk families. Rather than serve as a blueprint for providing this service, the manual is designed to educate interested groups in the potential uses of "shared family care" as a service option, and to identify the steps and information needed to initiate the development and implementation of this service. We expect that these guidelines contain information that can be customized by any organization to meet the unique needs of a particular community and clientele.

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Overview of Shared Family Care



SECTION I

- A. The Need
- B. An Alternative to Conventional Services
- C. Definitions
- D. Shared Family Care Models
- E. Case Vignettes

SECTION I

Overview of Shared Family Care

The Need

Children are placed in out-of-home care at increasing rates, with more than 230,000 new foster care placements each year (Tatara, 1995). These family separations are based on service providers' determinations that the risk of leaving a child at home is unacceptably high and outweighs the emotional risk of separating a child from his/her biological parents. Although federal law (P.L. 96-272) requires that every reasonable effort be made to prevent placement, often, the only alternative to separation is leaving a child at home under the periodic supervision of a child welfare worker. These in-home services are typically brief and require that a parent be able to provide a safe living arrangement at all times. Given the influx of very young and vulnerable children into foster care in recent years (Goerge, Wulczyn & Harden, 1995), protecting these children at home is often considered too tall an order. High foster care reentry rates for young children who do go home suggest that more needed to be done to ensure a prolonged parent-child reunion.

Inadequate housing or homelessness and substance abuse are frequently primary factors leading to foster care placement or preventing reunification (Nelson, 1992; Pelton, 1992). Human service professionals are continually searching for alternatives that provide safety for children and the opportunity for parents to achieve recovery. In some cases, children are removed from their parents' care and officially placed with extended family, with whom the parents also reside (Testa, in press). Yet, other parents are forced to relinquish their children to out-of-home care simply in order to receive necessary substance abuse treatment in programs which cannot accommodate children. Clearly, a child's separation from his or her parent may depend as much on the availability of a protective living environment as it does the parent's capacity to safely interface with her or his child.

Despite the widespread use of foster care, child welfare workers generally believe that, in most cases, biological parents are the most satisfactory caregivers for a child and have a basic right to provide this care (Berrick & Karski, 1995). There is also growing recognition of the grave consequences that placements outside the family have on children. Experience reveals that permanency of care is a determining factor for optimal early childhood development, and that both children and parents suffer significant trauma when they are separated (Larsson, Bohlin & Stenbacka, 1986; Piirto, 1994; Werner, 1985). Also, there is no guarantee that traditional foster care placements will offer a child the safety or stability that the biological family was considered unable to provide. In fact, as wards of the state, many children severely lack continuity of care. "Nationally, children entering foster care move an average of three times" (Cooper, Peterson & Meier, 1987), and "twenty-five percent of all children in foster care will experience three or more placements during their stay in the system" (Fein, 1991). This number may be even greater for children in long-term care. In California, for instance, of all children who were in non-kin foster care for at least four years since 1988, almost half experienced three or more placements (Needell, Webster, Barth, Monks, & Armijo, 1995).

Further, approximately one-in-five children who are reunified from foster care experience a subsequent out-of-home placement at some point (Courtney, 1995). Perhaps one factor contributing to this phenomenon is that when parents are separated from their children, they never have the opportunity to learn how to interact with them on a day-to-day basis or how to deal with the frustration which is a normal part of parenting. Additionally, during separation, neither parent nor child has an opportunity to adjust to the continual changes they both experience individually and in relation to others. Research also shows that the majority of child abuse occurs when there is stress on parents who themselves received deficient parenting and who experience isolation from their own families and other community supports (Gabinet, 1983). Having had no role models for good parenting, many adults must learn for the first time how to be effective parents while struggling with their own recovery and/or other personal issues (Barth, 1994; Finello, 1995). This does not mean that they are incapable of parenting. "Only by ensuring that parents have the support they need, and by working with them individually, emphasizing their strengths, encouraging success, and modifying techniques which are not working, can we expect them to be effective parents" (Finello, 1995, p. 8).

There is reason to believe that with appropriate support and training, some families can remain safely together or become permanently reunified without court involvement or traumatic separations. With a high rate of children reentering foster care, and the undesirable consequences of separating children from their parents, there is a great need to develop and determine the efficacy of alternative strategies whereby a child can continue to live with his/her parents in a protective, nurturing family environment.

An Alternative to Conventional Services

Shared family care offers another alternative in the continuum of services for families with multiple needs who are at high risk of losing custody of their children, or who have already been temporarily separated from their children. Shared family care has been defined as the planned provision of out-of-home care to parents and children so that the parent, supported by the host caregiver, cares for the child and works toward independent in-home care (Barth, 1994). The concept of shared care recognizes that, for a variety of reasons, some parents "are especially vulnerable to events or influences that may incapacitate them to some degree, and for some period of time in fulfilling the normative parent role [or that] some children have special needs that a family may not be able to supply unaided" (Kufeldt, 1981, p. 247). However, given the significance of a parent in a child's life, the importance of continuity, and the trauma of separation, shared care can be a preferable alternative to substitute care for some families. Shared family care combines the benefits of in-home services, which are not always enough, with out-of-home child welfare services, which may be unnecessary or ineffective. Ultimately, these arrangements may be effective in diverting unnecessary court involvement, reducing the length of stay in out-of-home care and preventing subsequent family separation.

For purposes of these guidelines, shared family care (SFC) refers more specifically to a situation in which an entire family is temporarily placed in the home of a host family who is trained to mentor and support the biological parents as they develop caring skills and supports necessary for independent living. SFC can be used for prevention—making it unnecessary to separate a parent(s) from her child, or for reunification—providing a safe environment in which to reunite a family that has been separated.

The sharing of parental responsibilities made possible through shared family care helps biological parents develop improved parenting skills and learn how to become adequate parents while dealing with their own personal issues. By providing a living laboratory in a safe, family environment, SFC helps families learn how to make good decisions, how to handle typical day-to-day stresses, and how to live together as a family. Kufeldt and Allison (1990) suggest that "an extended family concept provides opportunities for the family of origin to learn to nurture through the experience of being nurtured, and to learn more functional parenting roles through observation of positive family functioning" (p. 8-9). Nayman and Witkin (1978), who first described such a program in the professional literature, also note that a "healthy, functioning family is the most effective agency for socialization, role prescription and the instruction of parental skills" (p. 251). SFC allows parents to receive feedback about their parenting styles and skills on a 24-hour basis and across many and diverse parenting tasks (Barth, 1994). This opportunity for direct daily observation in a sheltered environment approximating a normal household may be the most effective method of evaluating parental skills (Nayman & Witkin, 1978).

Additionally, SFC preserves a family's ability to live together while ensuring the safety of the child and, as a result, avoids duplication of services and inefficient use of resources. Presumably, by allowing parents to live with their children as they learn how to become better parents, SFC results in a decreased number of children entering and reentering the foster care system. This ultimately should reduce expenditures in foster care, independent living programs, adoption, and shelters/temporary housing. At the same time, SFC may help some parents make the decision to terminate their parental rights. In these situations, SFC provides continuity for the child(ren) until more permanent plans are established, thereby protecting them from the instability of the foster care system.

SFC also helps families establish stable, ongoing connections with community resources, which is critical in the transition to independent living. It is expected that "residence in the community facilitates establishment of productive relationships with child care workers, medical professionals, counselors, job training and other education programs, and community programs. Living with a community-based mentor may model not only parenting, but also modes of community interaction and methods for utilizing community support systems" (Williams & Banyard, 1995, p. 10). Finally, SFC improves the community by providing employment, training and support to mentor families.

Definitions

Shared Family Care (SFC) is the planned provision of out-of-home care to parents and children so that the parent, supported by the host caregiver, cares for the child and works toward independent in-home care. For purposes of these guidelines, SFC refers to a situation in which an entire client family is temporarily placed in the home of a host family who is trained to mentor and support the biological parents as they develop caring skills and supports necessary for independent living.

Host Family is the family with which the client family lives. The host family may consist of a single adult or adults, with or without children, and serves as a mentor to the client. The host family may also be referred to as resource family, mentor, foster family or care provider.

Client Family is the family receiving services, and consists of at least one adult parent or guardian and one child. Although the parent(s) is the primary client and the "mentee," the entire family, as defined by that family, should be considered in the service plan. The parent in the client family may also be referred to as mentee, participant or student parent.

Dependent of the Court is used synonymously with "ward of the state" to mean a child who has been legally and temporarily removed from his parent's custody because of child abuse or neglect.

Sponsoring Agency is a public or private organization that provides funding for shared family care; establishes general program mission, goals and policies; identifies an implementing agency(s) (which may be their own); and develops and oversees evaluation of the program.

Implementing Agency is a public or private organization that conducts the day-to-day operations of shared family care. This organization may or may not be the sponsoring agency.

Shared Family Care Models

Various models of shared care exist, some dating back to the middle ages (McCoin, 1987). The mental health community has been using private homes to provide foster family care to mentally ill adults since the late nineteenth century (Carling, Levine & Stockdill, 1987). Foster care for the elderly is also burgeoning (Mehrota, 1991). The **South West Surrey Family Placement Team** in England uses "complementary care" in which foster care providers go into a child's home for very short periods rather than removing the child from its home environment (Cohen, 1994). Similarly, based on the *Contact Family Program* in Sweden, the **Family Match Program** at Spectrum Human Services, Inc. in Michigan, matches at-risk families with mentor families who model parenting and problem solving, provide occasional respite care, and support and guide the client family to self-reliance (personal contact with Program Supervisor, Catherine Livingston, 1995).

Texas Baptist Children's Home (TBCH) illustrates another model designed to prevent children from being taken into protective custody. TBCH operates two family cottages, in which two-to-three client families (single mothers and their children) live for an average of just over three months with one staff family per cottage (Gibson & Noble, 1991). The staff families provide role modeling and coaching in parenting and other life skills. Additionally, several programs across the country use a shared care concept in group homes and other larger residential facilities, and an increasing number of agencies are beginning to experiment with shared custody arrangements (e.g., joint guardianship and standby guardianship) for children of parents with AIDS.

Shared family care, as defined in these guidelines, is less common, although several agencies throughout the country have begun to use this model for adolescent mothers who are foster children themselves. **The Adolescent Mothers' Resource Homes Project** of the Children's Home and Aid Society of Illinois (CH&ASI) places pregnant and parenting teens, who are dependents of the child welfare system, in the homes of "resource parents," who are typically (but not always) single women who have raised their own children (Children's Home and Aid Society, 1994). The teen mothers assume full responsibility for the care of their children; the resource mothers assist the teens in developing the skills and finding the supportive resources they need for parenting, and offer them nurturance and support. All resource families must participate in an 8-week pre-service training, in addition to ongoing in-services and support groups. They are licensed as child foster homes and

compensated, through title IV-E and state funds, at roughly twice the standard adolescent rate, but well below the group home rate (i.e., the per diem rate is \$74.25, which is split evenly between the resource family—to cover basic needs of the client family—and administration). Each teen must sign a contract, along with all members of her resource family, her CH&ASI social worker and any other involved member of her family, clarifying each party's responsibilities and commitment to the others. The goal of the placement, which is intended to last an average of 6 to 18 months, is to prepare the mother to live with her child(ren) either at home with her family or independently, or to help the mother recognize if she is unable or unwilling to adequately care for her child(ren) and facilitate permanent plans for her and her child(ren).

Currently, we know of two programs using this model of shared family care for adult parents. Since 1990, Minnesota Human Service Associates (HSA), a treatment foster care agency, has sponsored placements of whole families with "host families" who are trained to mentor participating families through transition to independent living. The model is similar to treatment foster care in terms of staffing, training and foster parent reimbursement. HSA began providing this service for homeless families with funding from a private foundation. Presently, the **Whole Family Placement Program** serves families in a variety of situations, including parents reunifying with their children in out-of-home care, those infected with HIV, parents coming out of chemical dependency treatment or prison, parents with borderline intelligence, and those leaving battering relationships. Although most families consist of a single mother with one or more children, two-parent families and single fathers are also served through this program. Client families are typically referred by child protection and probation staff to prevent placement of children away from their parents, to reunite parents with their children who have been in substitute care, or to determine if termination of parental rights should be explored.

One social worker works with approximately 8-9 families at a time, and participates, along with each client and host family, in developing a written contract outlining each party's responsibilities. The client generally maintains primary responsibility for care of her child(ren), and the host family serves as advocate, resource and mentor in parenting, and daily living skills. Host families are licensed as child foster homes, and are reimbursed through county funds at a per diem rate of \$30 - 36.50 per individual in placement. This money is expected to cover the client's food and other basic living expenses while in placement.

Placements last from three months or less to over two years. Although the primary outcome objective is to keep families together while they work on identified problems and concerns and move toward "independent" living, the program also helps some families decide to terminate their parental rights and free their children for adoption. In these situations, the child(ren) can remain with the host family until a permanent arrangement is established. Between 1992 and 1994, 46 families participated in HSA's *Whole Family Placement Program*. Of those, 23 families moved on to independent housing and ended involvement with child protective services; eight families left their children in foster care (five of those were subsequently adopted); and 15 families continued in placement into 1995 (Nelson, 1995).

A New Life Program uses a similar model of whole family care as one component of its comprehensive service delivery system for African-American women who are addicted to crack cocaine, are pregnant or have infants, and have a history of out-of-home placement. *A New Life* was initiated in 1991 by its non-profit, community service parent organization, Crime Prevention Association of Philadelphia (CPA). For ten years, CPA has provided specialized foster care for delinquent youth in "advocate" homes in the community as an alternative to institutional placements. The primary goal of *A New Life* program is to help women gain sobriety and maintain abstinence without losing custody of their newborn children. Along with substance abuse treatment and relapse prevention, it also focuses on strengthening a woman's capacity to parent her child(ren) and to utilize community resources for assistance and support. To this end, many women are placed in mentor homes once they have demonstrated a capability and willingness to participate in the treatment program. Placements typically last three to six months and coincide with intensive, daily drug treatment and parenting skills training, with on-site day care provided five days a week. During the placement, each mother maintains her role as primary caretaker of her newborn, and receives support and guidance from her mentor.

A New Life mentors are women from the community who share the same cultural background as the clients, and who are trained to: support clients in their recovery, model good parenting behaviors, help assure clients' ongoing participation in the program, monitor their behavior, provide instruction in life skills, and provide them with a stable home from which to transition into independent living. In exchange, mentors receive \$300 per week. These stipends initially were provided through a National Center on Child Abuse and Neglect (NCCAN) grant, and are currently funded through county departments of

drug and alcohol abuse and child welfare. Unlike HSA's program, clients retain their AFDC and food stamp entitlements while in placement. *A New Life* places approximately 40% of each client's monthly AFDC check in a savings account for future housing, until the client completes the program. Clients must use the remaining amount, along with their food stamps, to pay for their own food and other personal needs. Upon completion of the mentor home placement, women move on to other transitional or permanent housing in the community. To address the lack of affordable housing in the community and the need for ongoing support, Crime Prevention Association renovated three homes which house six women with their children upon completion of their mentor placement. Women in these and other transitional living situations continue to receive training and support through *A New Life*, and continue to work toward reunification with older children in placement.

In the first two years of *A New Life* program, 44% of the clients entered a mentor home. Although only 11% of those women successfully completed the placement, they were more likely than those who never entered a mentor home to complete the overall treatment program (33 weeks of treatment compared to 20 weeks). Follow-up interviews with clients revealed the importance of carefully screening mentors and making good personality matches between mentor and client, and of the mentors allowing clients to make decisions and respecting their decisions without judgment (Williams & Banyard, 1995).

Table 2 in Appendix C presents the comparative estimated cost of these three very different models of shared family care. However, it does not necessarily reflect the minimum cost needed to provide SFC. Depending on the nature and goals of a particular program, the population served, the expectations of the host families and the resources available, it may be possible to design services which reap the benefits of shared family care with a smaller monetary outlay than these programs.

Case Vignettes

The following scenarios illustrate situations in which shared family care has been used to help families stay together:

- ◆ An abusive mother who moves frequently from home to home and who started off regularly visiting her children in two different foster homes but has recently begun to miss her visits.
- ◆ A married couple who are both methadone users, expecting a third child, and who have recently regained custody of their 3 and 4 year old children who were both prenatally exposed to drugs.
- ◆ A parent coming out of substance abuse treatment, who is homeless, unemployed and vulnerable to relapse, and who faces social service pressure for immediate reunification with her three children who all entered foster care after the youngest child was born.
- ◆ A parent with AIDS who loses her job, has a child to support, and seeks to ensure stability and continuity for her child as her disease progresses.
- ◆ A young mother who grew up in multiple foster and institutional placements, and has emotional issues involving disrupted family relationships, but who wants to retain custody of her infant.
- ◆ A single father who is homeless, completing an alcohol treatment program, and seeks to regain custody of his son.
- ◆ A single mother with a mild developmental disability and two young children whom she has neglected but is committed to parenting.
- ◆ A woman and her two children who, because of repeated emotional and sexual abuse from various family members, cannot safely remain in their current location; the mother is having difficulty consistently meeting the needs of her children as she struggles with her own reactions to the abuse, yet *she* is not abusive and the children are strongly attached to her.
- ◆ A pregnant woman who is a substance abuser and has a history of older children in out-of-home placement.

Guiding Principles and Anticipated Benefits



SECTION II

A. Guiding Principles

B. Mission and Anticipated Benefits

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SECTION II

Guiding Principles and Anticipated Benefits

Guiding Principles

Shared family care is based on the following general values and beliefs:

- ◆ Child protection is the foremost priority of child welfare services.
- ◆ Every child deserves a safe, healthy, nurturing environment in which to grow.
- ◆ Families should remain together (i.e., children should not be separated from their primary caregiver) if at all possible.
- ◆ In order to support a child, it is necessary to support the child's parent(s).
- ◆ Parents' basic needs must be met in order for them to effectively address psychosocial, emotional or parenting issues.
- ◆ Most children are better off in a family setting.
- ◆ Each family's unique way of nurturing and protecting children must be respected.
- ◆ Families have different ways of defining themselves, and extended family members are often important resources.
- ◆ Compatibility between host and client families is important and is achieved through comprehensive, individualized assessment and careful matching.
- ◆ Mentor families must be culturally competent to model positive, relevant behavior.
- ◆ Families should be placed in homes in which they are culturally comfortable, and in communities in which they can feasibly transition to independent living.
- ◆ Families learn best from each other.

- ◆ Most families can learn to set their own goals and take charge of their lives.
- ◆ Each family's goals/outcomes must be clarified from the outset and should reflect an understanding that the placement is one part of an evolving process of change which may be slow.
- ◆ Disposition/transition planning should begin as soon as goals are identified.
- ◆ Relevant and accessible follow-up services and support may be needed to help families move toward independent living in the community.
- ◆ Interagency collaboration is critical in order to provide integrated services which meet the needs of families.

Mission and Anticipated Benefits

The following mission and anticipated benefits can serve as a basis for the development of any shared family care program. Each agency implementing such a program can use this mission to guide them in developing a program which reflects its unique program components, clientele and program goals.

The overall **mission** of shared family care is to protect children by offering services to parent(s) and children together in a safe and supportive family setting which helps to preserve families or to facilitate the transition to other permanent arrangements.

Shared family care has the following potential benefits for children and families, the child welfare system, and the community.

CHILDREN AND FAMILIES

- ◆ Protects children at-risk for abuse or neglect.
- ◆ Preserves a family's ability to live together and prevents unnecessary separation of families.
- ◆ Provides continuity for children and families.
- ◆ Supports a family's move toward independence and participation in the community.
- ◆ Helps parents meet parental responsibilities, learn to make good decisions, and increase their competence in adequately meeting their children's needs.
- ◆ Provides models and opportunities for children and parents to succeed as a family.
- ◆ Helps families recognize a child's need for consistency and make decisions about the best alternative for their children's permanency.
- ◆ Facilitates alternative permanency plans (e.g., adoption) when family preservation cannot be achieved.

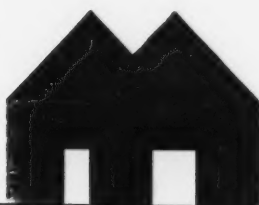
CHILD WELFARE SYSTEM

- ◆ Reduces the number of children in the foster care system.
- ◆ Reduces the number of children returning to out-of-home placement after the end of agency supervision.
- ◆ Reduces inefficient use of resources by coordinating and integrating agency systems and services.
- ◆ Reduces overall human services expenditures.

COMMUNITY

- ◆ Strengthens the community by increasing the number of well-functioning families and by providing host families with employment, training and support.
- ◆ Creates a more efficient use of community resources by allowing children and parents to be served together.
- ◆ Increases the options of services currently available to families.

Program Elements



SECTION III

- A. Agency Responsibilities
- B. Target Population
- C. Core Elements of Shared Family Care
- D. Rights and Responsibilities Agreement
- E. Service Planning
- F. Duration of Services
- G. Placement Termination
- H. Aftercare

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SECTION III

Program Elements

Agency Responsibilities

Shared Family Care (SFC) may be incorporated into the continuum of services offered by a state, local or private agency. If sponsored by a public agency, the service can be implemented directly by that agency or, more likely, contracted out through a competitive process to private organizations. The sponsoring agency should determine the specific mission and goals of the program and the target population. The implementing agency (i.e., the one which actually provides the service and may be the same as the sponsoring agency) will be responsible for:

- ◆ staff hiring, training and supervision
- ◆ client family intake and screening
- ◆ host family recruitment, screening and, if indicated, licensing
- ◆ client-host family matching
- ◆ host family training, supervision and support
- ◆ case management of client families (including coordinating the development of the initial family plan, overseeing its implementation and maintaining client records)
- ◆ interagency coordination
- ◆ conflict resolution among client and host families
- ◆ participating in evaluation design and implementation

To perform these tasks, program staff should include: a supervisor responsible for all activities involving host families, and for training and supervising the social workers/case managers; and one social worker/case manager for no more than nine (9) families. The case managers coordinate the development of individualized family plans (IFPs), coordinate

service delivery and transition planning, and review the IFPs with the client and host families on a regular basis. Once the plan is developed, case managers should have face-to-face contact with the client family *at least* twice a month and as often as needed.

This is the basic staff needed to implement SFC. Depending on the client population and the services provided by the implementing agency, other staff may include substance abuse counselors, mental health workers, child care workers, infant specialists or medical personnel.

Target Population

These guidelines focus on families headed by adults¹. In general, families eligible for shared family care consist of at least one parent who:

1. Is trying to retain (i.e., preserve) or regain (i.e., reunify) custody of one or more children;
2. Demonstrates a "readiness" to work on an individualized service plan designed to promote self-sufficiency and permanency for their child(ren);
3. Will benefit from living with a mentor family who will assist them in reaching their goals;
4. Requires some supportive service in order to adequately protect their children;
5. Agrees to participate in the program.

Aside from these general characteristics, specific decisions about which clients to accept for SFC will vary depending on the goals of the program, training of the mentors and services available to the clients. Each sponsoring agency must consider these factors when

¹Shared family care can also be effectively used for adolescent parents in foster care, as indicated by the success of CH&ASI's *Adolescent Mothers Resource Homes Program* (described in Section II). However, SFC programs designed for adolescents present some different issues related to client eligibility and goals, mentor responsibilities and training, licensing and financing. Mentor families for teen parents, for instance, must understand psychosocial and behavioral issues related specifically to adolescents, and be willing to work with the teens' biological families and schools. At the same time, SFC for adolescents closely resembles more traditional therapeutic foster care and is covered by conventional foster care licensing and financing.

establishing additional eligibility criteria appropriate for their particular program. For instance, an agency may require clients eligible for this service to have a history of out-of-home placement, be homeless, and/or be court dependent or involved with child protective services. Other agencies may use SFC specifically as a way to obviate the need for court-ordered services. It may be designed only for single mothers with one infant, or for families of any size and composition.

Perhaps the most useful initial criterion is that the family appears "ready" to benefit from the program. Each agency must establish its own method for determining "readiness," which, in all cases, should include consideration of each family's successes, strengths and potential resources. The most important indicators of a client's "readiness" are:

- ◆ a demonstrated desire to care for one's child and
- ◆ a willingness to participate in a service plan.

The following table includes guidelines for establishing additional indicators of "readiness" for several different, but not mutually exclusive, client populations that may be appropriate for shared family care. These indicators may help a program identify clients who are most likely to benefit from shared family care in an effort to either preserve or reunify a family.

Experience of HSA's *Whole Family Placement Program* and *A New Life Program*, along with insight from mentor families in these programs, suggests that whole family care *may not be appropriate* for clients who are:

- ◆ actively using alcohol or other drugs
- ◆ not "working the program" or complying with program rules
- ◆ actively violent or involved in illegal activities
- ◆ severely mentally ill without appropriate treatment or support, and not ready to work toward the transition to community life

READINESS GUIDELINES	
Primary Client Characteristic	Indicators of "Readiness"
Parent substance abuser	- has completed substance abuse treatment <u>or</u> is actively participating in outpatient treatment - demonstrates an interest in maintaining abstinence by actively participating in recovery services
Parent(s) discharging from prison or some other correctional facility	- maintained contact with child(ren) while in prison - has complied with prison release plan
Parent(s) with a chronic or acute physical illness or disability	- may require minimal medical assistance but is physically self-sufficient - if necessary, is willing to participate in permanency planning for child(ren)
Parent(s) with mental illness	- is receiving necessary treatment and complies with treatment plan (e.g., medication) - is mentally capable of caring for child(ren)
Woman with child(ren) transitioning from domestic violence shelter or situation	- understands the need to physically separate herself and her children from abusive family members
Parent(s) with borderline intelligence or mental capacity	- agrees to needing help learning how to care for child(ren) - has ability to meet own basic needs
Parent(s) with a medically fragile infant	- participated in hospital required treatment and discharge planning - understands the medical needs of child and is willing to learn how to care for that child

Regardless of the specific criteria used to determine readiness, it is critical for agencies to know as much as possible about each client family before considering a shared family care placement. This is important for liability issues (see Section V) as well as appropriate matching of clients with host families (see Section IV). Basic information the agency should obtain at intake includes:

- ◆ age and sex of all family members
- ◆ religion, ethnicity, cultural orientation and primary language
- ◆ behavioral/mental health problems of both parent and child(ren) and participation in current treatment
- ◆ medical or physical handicaps and participation in treatment
- ◆ history of dangerous or illegal behavior
- ◆ legal status and current living arrangements of all immediate family members
- ◆ other relevant (extended) family members and their whereabouts
- ◆ parental substance abuse history and current status
- ◆ educational level and needs of parent and child(ren)
- ◆ referral source and reason for referral
- ◆ client's reason for participation
- ◆ client's strengths and other indicators for readiness
- ◆ services client is currently receiving

Core Elements of Shared Family Care (SFC)

SFC must be considered as one alternative in a broad array of service options for families at-risk. Mentor homes should be developed as part of a comprehensive treatment or rehabilitation approach in which each client family receives appropriate support services identified through an individualized service plan. The homes should be viewed as training grounds for independent living with a focus on reconnecting families with community services and linking them to community resources which will last beyond the placement.

Each SFC program may look different, reflecting the mission and goals of the sponsoring agency, the target population being served, and the goals of that particular SFC program. The following core components, however, should be incorporated into any SFC program, regardless of the specific services provided:

- ◆ Rights and responsibilities agreement
- ◆ Individualized service plan for each client family
- ◆ Recruitment, training, supervision and support of host families
- ◆ Careful matching of host and client families
- ◆ Peer groups for mentors and clients
- ◆ Respite for mentors
- ◆ Training for referring agencies, judges and attorneys, and agency staff
- ◆ Program evaluation

This manual contains a discussion of each of these core components, along with guidelines and considerations for designing the specific elements of a SFC program.

Rights and Responsibilities Agreement

A written **Rights and Responsibilities Agreement** may help reduce conflict and disagreement which people living together inevitably encounter. Each client family should participate in the development of an individually negotiated document which is agreed to and signed by all relevant parties. Participants involved in developing and abiding by this agreement should include the client, host family and agency social worker/case manager, and may also include any other key people in the client's life. (See sample agreements in Appendices B1 and B2.)

The agreement should specify the rights, responsibilities and expectations of each party, specify the limits of confidentiality, and include provisions for the child(ren)'s supervision. In general, parents in shared family care are expected to assume primary responsibility for the care of their children. Host families are expected to act, not as substitute parents, but as caring adults prepared to guide the parents and model appropriate caregiving

behavior. However, the division of tasks, activities and decision-making, and the level of responsibility of each party must be determined by each client/mentor household, with consideration of the services available through the sponsoring agency. All this should be specified in the agreement. In *A New Life Program*, for instance, the sponsoring agency provides five-day-a-week child care; whereas another program might expect the host family to assist with this responsibility either directly or by helping the parent access other community services.

Also, while the mentor should encourage the parent to assume primary decision making and parenting responsibilities, this division of labor must be considered in the context of the parent's skill level and emotional and physical well-being. If, for example, the parent takes on a level of responsibility which places them or their children at risk, the mentor must guide or direct the parent in an effort to prevent such harm. At the same time, specifying the division of tasks in the written agreement will help prevent situations in which, for example, a parent expects the mentor to do the majority of tasks associated with the care of their child. (See Section IV for additional information on host family responsibilities and expectations.)

The agreement should also include a provision enabling any party to terminate the agreement with a notice of a predetermined length of time (e.g., 30 days). This allows time for both parties to work through a difficult situation. It also provides an opportunity for the agency to help resolve the conflict or, if necessary, help the client family enter a different placement or link them to alternative services.

Service Planning

After completing the Rights and Responsibilities Agreement, an **Individualized Family Plan (IFP)** should be developed for each client family within the first 30 days of placement. The plan should be developed jointly by the client family and the family support team which includes: the host family, the agency social worker/case manager and, if indicated, other critical players, e.g., child welfare social worker, infant or child development specialist, substance abuse counselor, psychologist, parole officer, extended family members, educators, health professionals, and/or a support person of the client's choice. Each IFP should consider the family's successes, strengths and potential resources, as well as

their resource, support and counseling needs for achieving independence or making permanency plans for their children. The IFP should be a workable document which identifies short and long-term goals and agreed upon services to be provided (see Appendix B3 for a sample placement plan). It, along with the Rights and Responsibilities Agreement, should be reviewed by the family and the support team on a regular (e.g., monthly) basis. In developing the IFP, clients should be encouraged to prioritize their goals and limit the number they identify to a few attainable and manageable goals. Depending on the target population and the mission of the sponsoring agency, client goals identified in an IFP may include:

- ◆ Developing personal self-care habits (e.g., health, nutrition, sleeping)
- ◆ Staying in treatment (e.g., mental health or substance abuse) as indicated
- ◆ Developing a strategy for economic independence (which may include temporary aid while receiving training or seeking employment)
- ◆ Obtaining long-term transitional or permanent housing
- ◆ Developing certain parenting, basic living and/or job skills
- ◆ Regaining custody of child(ren)
- ◆ Establishing connections with community resources

Although service needs will change, services which client families in SFC may need should be identified in the IFP; these include:

- ◆ Medical services
- ◆ Substance abuse treatment and/or recovery support (Note: it is critical that relapse prevention and related services be built into any program providing SFC for clients in recovery)
- ◆ Health and nutrition education
- ◆ Mental health counseling for parents and children
- ◆ Education on parenting and child care and safety
- ◆ Life skills training (e.g., budgeting and money management; shopping, meal planning and food preparation; planning ahead; developing a daily/weekly routine; understanding consequences)

- ◆ Family planning services
- ◆ Early intervention services for infants and young children
- ◆ Special education services for children
- ◆ Adult education, job training or employment assistance
- ◆ Linkage to community resources
- ◆ Communication skills, e.g., how to negotiate relationships
- ◆ Legal counseling and advocacy
- ◆ Therapeutic or regular child care
- ◆ Peer counseling/support groups
- ◆ Transition planning
- ◆ Transportation

Each organization implementing SFC will provide a different combination of these (or other) services, reflecting the nature and goals of the program, specific needs of its clientele, and resources available. The family support team should share responsibility for helping the client families attain their identified goals. Specific services may be provided directly by the implementing agency and/or through referral to other community agencies. In the model used by *A New Life Program*, for example, the SFC sponsoring agency provides all the support and treatment services (e.g., child care, recovery support, substance abuse treatment, parenting education, life skills and job readiness training), many of which are required for families in placement. HSA's *Whole Family Placement Program* illustrates a second model in which the SFC sponsoring agency provides case management, but links clients to community resources for most other identified services.

Duration of Services

Experience of *A New Life's* mentor home placements and HSA's *Whole Family Placement Program* indicates that, because of the importance of carefully and appropriately matching host and client families and of having the client's commitment to participate, SFC does not appear optimally designed as an emergency crisis intervention, but should,

rather, be designed for families in transition. The length of time needed for transition, however, will vary among and within programs. In follow-up interviews with *A New Life* clients, for instance, 64% felt that three months was too long to live with a mentor, yet 79% stayed for four to eight months, and several suggested that the placement be extended (Williams & Banyard, 1995). An experienced SFC provider from HSA's *Whole Family Placement Program* suggested that it takes at least two to three months to accurately assess the needs and strengths of a family in placement, and that a minimum of nine to twelve months in placement is necessary to affect significant behavioral changes in the family. Clients in HSA's program have remained in placement for as long as two years, which is the county's limit for reimbursement. On the other hand, Williams and Banyard (1995) found that effectiveness of *A New Life's* mentor home placements leveled off after six months in placement, after which time clients typically became dependent on their host families and less motivated to progress beyond the comfort of their placement.

Based on these experiences, we recommend that shared family care placements generally last a minimum of three months, with assessments at the end of the first three months and every 60 days thereafter. It is possible that a family in the reunification process or escaping a domestic violence situation may need less than three months in placement; whereas, a family with multiple and longstanding issues may need a longer time to develop critical skills and gain enough stability to live "independently." Regardless of the expected length of stay for a family, the goal of independent living and/or permanency for the child(ren) should be clearly articulated at the beginning of each placement. At that time, a preliminary transition plan should be developed and include criteria for when to terminate placement.

Placement Termination

Each sponsoring agency should establish discharge policies which address procedures for:

- ◆ unplanned termination (e.g., if the client family leaves without notice)
- ◆ termination based on misconduct or breach of agreement
- ◆ termination based on planned discharge criteria

More specifically, written procedures should detail appropriate action to be taken if the parent leaves unannounced with her child (e.g., how many attempts should be made to contact her? should they be readmitted to the program and, if so, with the same mentor family?), or without her child (e.g., who will care for the child in its parent's absence?). Policies should also clarify specific client conduct (e.g., violence or illegal activity), or host family conduct (e.g., abuse or corporal punishment), that will result in placement termination. Written grievance procedures for clients or mentors who disagree with the agency's decision should be clearly articulated.

Additionally, policies should identify specific criteria for planned termination. This criteria will depend on the focus and goals of the SFC program and the needs of the clientele. It may include, for instance, having necessary community supports in place, improved parenting skills, and completion of a substance abuse treatment program. Placement termination, however, should be determined on an individual basis and should be based on a client's "readiness for the next step," rather than attainment of ultimate goals. The client and host families should work together with the agency social worker and, if indicated, an outside agency social worker to determine when the placement should be terminated. Note that if the child welfare or probation department is involved, their final approval for discharge may be necessary.

Once a decision is made to terminate a placement, the transition should be seen as a process in which some supportive services are provided throughout and beyond the family's move out of placement. The agency is responsible for facilitating this transition to independent living or some other transitional situation. In *A New Life*, for example, clients who leave their mentor placement prior to successfully completing all their placement goals can continue to receive support services through the program in order to graduate to independent living. Host families can also be encouraged to assist with this process through continued support—either formally or informally.

In some cases, clients in a SFC placement may decide to terminate their parental rights. When this happens, the agency must work on a permanent placement for the child. Ideally, the host family will choose to adopt the child. At a minimum, the host family should continue to provide temporary care in order to give the child some continuity until a more permanent arrangement is made. In some programs, however, this may be impossible depending on if and how the host families are licensed (see related licensing issues in Section V).

Aftercare

Most families will continue to need support and other services following their placement. In some instances, this may include housing and other necessities, whereas other families may only need support and reassurance. An experienced care provider in HSA's *Whole Family Placement Program* reports receiving frequent calls from clients in their first months after placement. Calls ranged from very specific questions or requests (e.g., help finding child care) to requests for general support (e.g., when parents felt lonely or overwhelmed). Aftercare planning should address the following basic needs:

Health Care

Housing (e.g., help locating and obtaining an apartment)

Income

- ◆ employment assistance
- ◆ child support
- ◆ welfare or other entitlements (e.g., SSI)

Social Support

- ◆ formal (e.g., peer support groups, link to family resource center)
- ◆ informal (e.g., relatives and friends)
- ◆ crisis intervention

Child Care and Respite Care

Education

Infant and Child Development

Civic Skills

- ◆ relating to teachers and other school personnel
- ◆ community involvement and recreation
- ◆ voting

Also, "it is likely that parenting skills training and modelling of good parenting needs to continue" after placement, and "it may be particularly important to continue to address issues of child care and good parenting at each stage of child development..." (Williams & Banyard, 1995, p. 63).

It is critical that resources be available to help families meet these needs after placement. Aftercare services may be provided by agency staff—directly or through referral, and/or by the host families. In HSA's *Whole Family Placement Program*, for example, the agency uses funds from a private foundation to compensate host families \$12/hour for providing up to six weeks of aftercare services to client families who complete placements in their home. After this, many care providers continue to provide informal support for an indefinite period, especially for clients who have no other family or who choose not to return to their family of origin. A *New Life Program*, on the other hand, encourages client families to continue to access program services after placement, but does not expect (nor forbid) mentors to provide any ongoing support.

To address the lack of safe affordable housing in the community, A *New Life Program* also provides transitional housing for families after they complete their mentor placement. Crime Prevention Association, A *New Life's* parent agency, purchased and renovated three homes which provide space for nine women to live along with their children. Funded by the Philadelphia Office of Services to the Homeless and Adults, with a small portion of the clients' AFDC payments, these homes provide a safe, supportive place for families to live while they continue to participate in daily treatment activities through A *New Life*, and move toward more permanent situations. This type of less formal shared care arrangement offers a partial solution to the lack of affordable housing and allows families leaving mentor placements to continue to support and learn from each other, thus preventing the isolation which many of these families experience.

Several programs across the country help single mothers find shared housing and support these women by facilitating house meetings, teaching conflict-resolution skills and helping them figure out positive discipline approaches (Tepperman, 1994). Women who have participated in *Innovative Housing* (one such program in San Francisco, CA) have cited the following advantages to this arrangement: economics, the ability to talk with another adult and discuss day-to-day struggles, having a family, help with child care, and even to "share a cookie recipe." Many county housing agencies have funds available—usually through low-interest and deferrable loans—to purchase this type of housing for low-income families.

Host Families



SECTION IV

- A. Qualifications
- B. Recruitment
- C. Host-Client Matching
- D. Responsibilities
- E. Compensation
- F. Training
- G. Supervision and Support

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SECTION IV

Host Families

Host families have been referred to as: mentors, care providers, foster families or resource parents. Regardless of their title, they are, perhaps, the most critical element of shared family care placements. Therefore, careful consideration must be given to their recruitment, responsibilities, compensation, training, ongoing supervision and support.

Host Family Qualifications

All members of a host family must be non-judgmental and committed to helping families with multiple issues. They should also be willing to participate in training and accept agency supervision. Specific qualifications of host families, however, will depend on the nature of the program (e.g., the general goals of the program, the clientele it expects to serve and the responsibilities of the host families), as well as the applicable licensing regulations. The following suggestions should provide guidance in establishing recruitment criteria.

CULTURAL SIMILARITY

Mentors should, to the extent possible, be culturally similar to the families they are hosting, and be able to provide an environment in which the client family feels comfortable. The relative importance of matching client and host families on the basis of cultural similarity is likely to vary among clients. Whereas some clients have indicated that cultural similarity is not a significant issue for them, other clients may feel more comfortable and more connected to families with similar beliefs and traditions. Agencies must recognize the importance of this issue and, to the extent possible, seek to place clients with culturally similar families. Either way, mentors must respect the ethnic and cultural values, beliefs and practices of the families placed in their homes.

FAMILY COMPOSITION

The focus of the program and the clientele being served will partially determine the ideal family composition for host families. In *A New Life Program*, for instance, all mentors are African American women, reflecting the clientele for whom the mentors are expected to serve as role models. In general, clients escaping domestic violence situations should be placed with single women. Otherwise, single parent families can be placed with a couple as long as both families are comfortable with the situation, the mentoring addresses issues germane to single parents, and all host family members are included in the Rights and Responsibilities Agreement. On the other hand, single female care providers in HSA's program stated that they would feel uncomfortable accepting a male client into their home. For this reason, and to ensure that fathers also have role models, two-parent client families and single fathers should generally be placed in homes with a male and female mentor. Additionally, it is important to ensure that children of host families are adequately cared for, and it is recommended that families with very young children generally be discouraged from participating in shared family care as host families.

SUBSTANCE ABUSE HISTORY

Programs designed specifically for individuals in recovery may choose to select mentors who have personal experience with substance abuse. However, this is not necessary if appropriate training is provided and the mentors are sensitive to the experiences of their clients and understand the nature of relapse. On the other hand, mentors who are in recovery or have overcome other debilitating experiences must demonstrate that they have "worked through" these issues so that they no longer negatively impact their lives.

PARENTING EXPERIENCE

Although parenting experience is helpful, and therefore desirable, it need not be an absolute criteria if mentors demonstrate a knowledge about parenting. In fact, what may be even more important is a mentor's understanding of and ability to communicate effectively with adults (e.g., resolving conflicts and disciplining/confronting adults in a way which preserves their dignity) and a strong interest in working with families.

RESOURCEFULNESS

Shared family care providers should demonstrate their resourcefulness in meeting the needs of their own family, and a familiarity with community resources. Additionally, they should have their own support system which may come from family members, friends, and/or local organizations (e.g., churches) or social groups (Myers, 1992).

PHYSICAL SPACE

Shared family care homes must have sufficient space and furnished rooms in adequate living condition for the families they will host. These specifications will depend a great deal on conditions required by the applicable licensing regulations (see Section V). If the homes are not licensed, client families should, at a minimum, have a sleeping area which is separate from the sleeping area of host family members and is furnished with appropriate sleeping furniture (e.g., a crib if they have an infant). Duplexes can be used successfully, although their use may diminish opportunities for modeling daily routines and interactions. In all cases, homes should be in a state of good repair and sanitation, free of safety hazards and in compliance with all applicable local and state health and safety laws or regulations. (See Appendix B4 for sample Home and Safety Requirements.)

LOCATION

Generally, host families should come from the same community as the clients or from a community to which the client family might reasonably relocate. This is important so that clients are close to services and can begin to develop critical linkages to community resources necessary for independent living. Unless adequate transportation is provided, proximity may be particularly critical in programs, like *A New Life*, in which clients must participate in center-based services on a daily basis. When remaining in their own community may not be desirable because clients are escaping violent situations or situations that are more likely to trigger drug relapses, it may be more beneficial for them to live with a family in a different neighborhood where they can begin to develop their own new support network.

Host Family Recruitment

In SFC, host families are expected to provide mentoring and guidance to the parent(s) so that the parents can care for their own child(ren). This vastly different focus from traditional foster care may deter child-focused foster parents from hosting whole families. Nevertheless, these providers should not be overlooked in SFC recruitment efforts. Several providers in HSA's *Whole Family Placement Program*, for instance, became mentors after years of frustration from seeing children who they cared for as traditional foster parents return to the system after unsuccessful reunification efforts (personal conversations with HSA caregivers, 1995). These care providers see SFC as a more effective and

efficient way to protect children and ensure that they remain safely and permanently with their family of origin or another permanent caregiver. Also, some traditional foster parents, although not interested in hosting families themselves, may be good referral sources to other potential host families. Experience of both HSA's *Whole Family Placement Program* and *A New Life Program* bears out the general findings that word of mouth is the most effective recruitment method for host families (Myers, 1992).

Host family recruitment should be tailored to fit clients' needs, the nature of the program, its geographical location, and the services available. In general, strategies which have proven effective in recruiting traditional foster parents should also work with shared family care providers. Pasztor and Wynne (1995) recommend that a recruitment plan for child foster care providers include the following four components:

- ◆ Diverse, continuous public awareness and education
- ◆ Positive themes and messages which focus on the motivations that other providers identify as effective [(e.g., the ability to help children remain with their families of origin and prevent them from being subject to the revolving door of the foster care system)]
- ◆ Specific strategies which include: word of mouth from other care providers (which may be encouraged through bonuses for providers who bring in new providers, and encouraging providers to bring friends to support group meetings); local newspaper ads; radio and television public service announcements; notices at professional and occupational organizations, religious organizations, community centers and volunteer agencies; and recruitment rallies offering incentives (e.g., free groceries).
- ◆ Targeted campaigns around specific populations [(e.g., families affected by substance abuse; medically fragile children; families affected by HIV)]

HSA has also had considerable success recruiting and using host families that had previously lived in very troubled circumstances and successfully solved their problems. Similarly, the *Living in Family Environments (LIFE)* program in Michigan uses state mental health and social service funds to recruit, train and compensate former public assistance families to care for developmentally disabled children and adults in their homes (Myers, 1992). JTPA and JOBS funds also may be available to educate and train such families in transition to become a resource to new families.

Regardless of the specific recruitment strategy employed, Pasztor and Wynne (1995) highlight the importance of having a plan for a structured, positive response to inquiry calls. Follow-up procedures should include an application (see Appendix B5 for *A New Life* Program's mentor application and employee contract), an interview with the program director or supervisor (and possibly an experienced mentor), and a site visit to the prospective host family's home.

Host-Client Matching

Careful matching of host and client families is critical to the success of a whole family placement and should be based on individualized assessment. Each prospective "match" should have two-to-three pre-placement opportunities to interview each other, and at least one trial over-night. It is recommended that the placement process include the following steps:

1. After assessing the client family, the social worker makes an initial placement recommendation and informs the prospective host and client families about each other.
2. An initial, introductory meeting between the social worker and the two families is scheduled.
3. Both families have up to three or four days to consider the arrangement.
4. Assuming both families agree, a pre-placement meeting takes place in the home, during which time the families learn more about each other and establish specific house rules. House rules may address issues such as: physical punishment, time-outs, phone use, nutrition, smoking, visitation, meal times, household chores and television use. These are in addition to the general ground rules established by the sponsoring agency (see Appendix B6 for samples of general agency house rules).
5. The Rights and Responsibilities Agreement is signed and the client family moves in.
6. Once the family moves in, there is a two-to-three week assessment period before a full individual service plan is developed and signed. At any point during this process, either party can opt out of the placement, in which case a different host family is identified and the process starts over with the initial meeting. By giving each family an opportunity to decide with whom they are comfortable, this process helps eliminate clients who drop out of the program because they do not like the specific house rules or the host family. It also empowers the clients by recognizing and granting their right and ability to make their own decisions.

Host Family Responsibilities

A host family's primary responsibility is to help clients address their identified needs in order to adequately parent their child(ren). The specific tasks and expectations, however, will differ slightly for every family and among programs. For instance, a mother with HIV may need emotional support and assistance meeting the basic needs of her child(ren) during periods of her own physical incapacitation. A parent with borderline intelligence may need assistance in developing basic parenting skills and learning how to be consistent with her children and how to develop and follow through with daily plans.

Regardless of a client's specific needs or resources, however, all host families should be expected to:

- ◆ Communicate regularly with program staff and others involved with the client, participate in team meetings, and complete required progress reports.
- ◆ Participate in the client's treatment or service plan and assist them in meeting their goals.
- ◆ Cooperate with the evaluation team and complete any necessary documentation.
- ◆ Help link the client to necessary community resources to maximize the client's integration into the community.
- ◆ Help the client establish healthy, appropriate routines for themselves and their children, plan ahead and understand consequences of their behavior.
- ◆ Help the client meet the physical, emotional and educational needs of their children.
- ◆ Ensure, to the extent possible, the safety of the child(ren).
- ◆ Include clients in decisions which affect all household members.
- ◆ Maintain confidentiality within legal limits.
- ◆ Understand and fulfill responsibility as a mandated reporter.
- ◆ Assist with client's transition out of placement and be available for follow-up support or consultation.

(See Appendix B7 for A New Life's mentor job description.)

Specific tasks may include:

- ◆ Assist client with menu planning, grocery shopping and cooking or provide meals when necessary.
- ◆ Encourage client's participation in their children's school and/or other activities.
- ◆ Teach client budgeting and money management skills.
- ◆ Plan recreational family activities (e.g., taking the family to the zoo, the park or a friend's or relative's house).
- ◆ Help client establish reasonable and positive sleeping habits.
- ◆ Teach client positive socialization skills.
- ◆ Help client develop appropriate dress and personal grooming habits.
- ◆ Help client develop proper nutritional habits, regular meals and appropriate mealtime behavior.
- ◆ Provide or arrange transportation to treatment, meetings or other appointments.
- ◆ Help client obtain regular and emergency medical treatment for self and their children.
- ◆ Model and offer advise on positive, healthy and developmentally appropriate methods of caring for their child(ren).
- ◆ Provide planned and negotiated respite child care.

(See Appendix A for specific services which may be appropriate for different populations.)

Host Family Compensation

The level of reimbursement for a host family may depend on the local costs of living and community standards, the source(s) of funding, and the responsibilities of the host family. A host family's compensation should also reflect the basic necessities (e.g., food) they are expected to provide and whether their daily responsibilities prevent them from having an additional job outside the home. For instance, hosting a family should not be a 24-hour-a-day job; some clients work during the day, some sponsoring agencies (e.g., *A New Life*

Program) provide full day child care, and others may be able to obtain child care within the community. HSA's *Whole Family Placement Program* and *A New Life Program* illustrate two different methods of compensating host families.

Through county general funds, Minnesota HSA receives a daily rate of approximately \$50 per individual in whole family placement (e.g., the per diem for a single parent with one child would be \$100, a single parent with two children would be \$150, etc.). HSA retains approximately \$15 - 20 of each \$50 for administrative and operating expenses, and gives the remaining \$30 - 36.50* to the care provider for basic living expenses. Because clients are not expected to purchase and prepare their own food, and are not seen as "maintaining a household," they can not receive AFDC or food stamp benefits while in placement. Care providers are, therefore, expected to use the per diem to provide basic necessities (e.g., food, toiletries, etc.) for the client families. Care providers also give a portion of this income (approximately 20%) to the clients for their personal needs (e.g., clothing, diapers, toys) and savings. Additionally, HSA care providers receive paid respite for 3/4 day per month, which they feel is insufficient, particularly for single care providers (personal conversations with HSA care providers and staff, 1995).

Mentors in *A New Life Program* receive a weekly stipend of \$300 per family (which typically consists of a mother and infant). Initially, these funds were provided through a National Center on Child Abuse and Neglect (NCCAN) grant, which expired. Currently, the stipends come from a combination of funds from the local office of drug and alcohol abuse programs and county child welfare funds. Some mentors also supplement this income through additional work in- or outside their home. Mentors are expected to provide living facilities, including furniture and utilities, as well as various support services. Unlike HSA, however, clients in *A New Life* are expected to purchase their own food and other basic necessities and, therefore, are able to retain their food stamps and a portion of their AFDC benefits if they are otherwise eligible**.

*Care providers are eligible for a 1-5% merit raise when they are relicensed annually.

**While in placement, *A New Life Program* places approximately 40% of each client's AFDC payments in a savings account for their future needs (e.g., housing) when the client leaves the program or continues onto transitional housing.

These are just two methods of compensating host families using completely different funding streams. Depending on the resources available in the community and the structure of a particular program, other combinations of financing may be possible at potentially less cost. To the extent possible, client families should be expected to participate in financial responsibilities and budgetary decision making. For instance, up to 30% of a client's AFDC, or a small portion of an employed client's income, can be used for "rent" to the host family. This will help compensate the host family and help the client family learn important budgeting skills.

Also, in addition to monetary compensation, some communities may be able to provide low-income host families with financial support to rehabilitate their homes in order to accommodate an additional family or meet licensing or agency regulations. For instance, the *Living in Family Environments (LIFE)* program, funded by the Michigan Departments of Mental Health and Social Services, pays former public assistance families an annual salary of \$21,800 (with medical benefits), and an additional \$3,000 to up-grade their homes, in order to care for developmentally disabled children and adults (Myers, 1992). This may be critical in attracting families who are interested in hosting a family but do not have the space or cannot meet the housing standards required by licensing regulations. It also may be an effective and useful strategy for helping potential host families escape the public welfare system while assisting other families in need. (See Section VI for more information on potential housing rehabilitation funds and other possible financing sources.)

Training

Specific training needs will depend on the goals of the program, the targeted clientele and the experiential background of each host family. However, it is imperative that all SFC providers receive initial training, which must be culturally relevant and include, at a minimum:

- ◆ an overview of the program concept, policies and procedures (including confidentiality issues and child abuse/neglect reporting procedures)
- ◆ skills for teaching, communicating and working with adults (e.g., establishing rapport and trust, listening skills, non-judgmental conflict resolution, and disciplining and confronting adults in a way that preserves their dignity)

- ◆ the process of shared parenting and allowing parents to make decisions and mistakes
- ◆ basic information on issues relevant to the program population, e.g., infant and child development, child safety, substance abuse and recovery/relapse, mental illness, physical and sexual abuse, HIV prevention and treatment
- ◆ information on community resources and how to access them

Beyond the initial training, host families should help to identify their own ongoing training needs, which should be addressed through in-services on at least a quarterly basis. In HSA's *Whole Family Placement Program*, for instance, care providers use their monthly support group with the agency social worker to identify group training needs on a quarterly basis. To supplement this ongoing training provided by the agency, HSA gives each provider \$200 per year for additional training they can pursue on their own. In *A New Life Program*, mentors meet as a group twice a month, and often use these meetings to address ongoing training needs.

Along with the issues covered in initial training, which should be reinforced continuously, other specific issues to be addressed in ongoing training may include:

- ◆ problem solving and assessment
- ◆ smoking cessation
- ◆ developmental delays in infants and young children
- ◆ cultural and racial competence
- ◆ infant and child wellness/well-baby care
- ◆ parent/child attachment and bonding
- ◆ mental health care for infants, children and parents
- ◆ working with extended family members
- ◆ managing stress (mentors' and the clients')
- ◆ nutrition
- ◆ building self-esteem
- ◆ dealing with anger
- ◆ dynamics of family violence
- ◆ permanency planning
- ◆ legal advocacy and working with the courts

All training should be provided through a variety of approaches which may include:

- ◆ problem-solving activities
- ◆ role playing
- ◆ videos
- ◆ group discussions
- ◆ interaction with current host families and current or "graduated" clients

Supervision and Support

Responsive supervision and sufficient support are critical to retaining host families and ensuring that the clients receive appropriate, high quality service. A recent survey found that traditional foster parents who quit the system were frustrated and discouraged by unsympathetic caseworkers and by lack of support from child welfare agencies (U.S. Department of Health and Human Services, 1995). Assuming that host families in SFC require a similar level of support and understanding, it is critical that supervisors and client social workers be trained in interacting and communicating with host families as integral members of a team.

The supervisor should meet formally with host families, individually and as a group, on at least a monthly basis. Additionally, as in HSA's program and *A New Life*, the supervisor should be available to the host families 24 hours a day. The individual meetings provide an opportunity for the supervisor to assess the host family's performance and for the host family to express concerns and needs (e.g., training, counseling, respite). The group meetings serve as a formal peer support where host families can learn different approaches to mentoring families, share experiences, gain support and develop friendships and informal networks for things such as child care, recreational activities and transportation. This support and networking is critical for retaining shared family care providers. The group meetings also help the supervisor understand what is working and what needs to be changed in the program, and to identify group training needs.

Respite care must be available for host families, particularly if they are expected to be available 24 hours a day. As in HSA's program, care providers may provide respite for each other. However, the sponsoring agency should develop some formal mechanism for making respite available. Most communities will have some formal and/or informal respite

care services already in place that may be available through public or private agencies. This may include formal programs (i.e., with trained staff) or informal networks (e.g., parent cooperatives, or state or local cash subsidies to purchase respite through friends or relatives). The sponsoring agency may also establish a pool of money specifically set aside for respite, or a voluntary group of "on call" respite care providers (e.g., individuals in training to become host families, or those who are interested but do not have the space or are unwilling to make the long-term commitment). Respite can be provided in the host family's home or out-of-home in:

- ◆ a center-based day program;
- ◆ another family's home;
- ◆ a residential group facility; or
- ◆ a respite house specifically designed for 24 hour respite care.

The sponsoring agency may also locate a hotel that is willing to provide the host family with a room and meals while a local respite program provides care in or out of the mentor's home.

Licensing and Liability Issues



SECTION V

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SECTION V

Licensing and Liability Issues

Each sponsoring agency will have to determine if and how to license SFC homes. This decision will depend on the services being provided to families in care, state and local licensing regulations, and financing that may be available. Like Minnesota HSA's *Whole Family Placement Program*, agencies may license mentor homes as child foster homes. In Minnesota, this requires HSA to request a waiver from the state foster care licensing agency, allowing an adult to reside in a licensed child foster home. This option allows a child to remain in the mentor's home with the same care provider if the parent relinquishes her or his rights or is otherwise separated from the child. It also may enable agencies to access certain funding streams (e.g., IV-E funds) only available to licensed foster homes. At the same time, the dependency implied by foster care licensure may make it more difficult to access certain federal benefits (e.g., AFDC), particularly if other federal funding streams are being used (see financing discussion in section VI).

On the other hand, because SFC serves intact families in private homes, licensure may not be needed at all. In this case, however, agencies should establish some certification process to ensure that mentor homes meet certain basic criteria (e.g., in regards to space, safety, etc.). *A New Life*, for instance, is licensed as a substance abuse treatment program, but the mentor homes are not licensed as foster homes. Although *A New Life* does certify that the homes meet certain basic foster home criteria, they consider placements as a return home rather than out-of-home care, and expect the clients, not the mentors, to provide for their own basic needs while in placement.

By choosing not to formally license homes, agencies may be able to expedite placements by avoiding a lengthy licensing process (often three or four months) involving the department of social services. It also may be easier for client families in non-licensed homes to retain their AFDC and food stamp benefits by treating the placement more like a shared

living arrangement in which each family provides for its own basic needs. This option, however, may only be available to private agencies implementing SFC because public agencies are typically required to fully license all foster care homes in which care and supervision are provided. Also, without a license, neither the provider nor the client has the legal protection or recourse available to families in licensed homes.

Given the diversity of licensing regulations among states, each agency must carefully explore the relevant laws, regulations and waiver policies in their community to determine the most logical way to license their SFC homes. It may also be possible to work with the appropriate agency (e.g., social welfare, mental health, substance abuse) to create in statute a separate licensing and certification process for shared family care. This, however, will typically involve a lengthy process. The following chart outlines several licensing options (which may not be available in all states) and some advantages and special considerations of each.

LICENSING OPTIONS		
Type of License	Advantages	Special Considerations
Child Foster Care	- enables child to remain in care if biological parent relinquishes rights - may provide insurance coverage - better protects the client from abuse through state monitoring and insurance that the provider has met standards - opens up possibility of certain funding streams only available to licensed foster homes	- necessitates involvement with courts and the child welfare system - licensing process can be fairly lengthy (e.g., 3-4 months) - may require a state waiver
Adult Residential Facility	- may open up possibilities for certain funding only available to adult facilities	- current statute may prohibit children from living in adult facilities - may need to purchase insurance
Dual (Child & Adult) Licensure	- combines advantages of child and adult licensure	- most states will not allow - may require statutory changes, which may take a very long time - if allowed, must meet requirements of both child and adult facilities
Certification without Licensure (i.e., compliance with foster care home criteria without completing the state licensing process)	- avoids involvement with state bureaucracy, lengthy licensing process, and possible waiver requests - ensures that providers have met certain standards	- may need to purchase separate liability insurance if foster care policy only covers licensed homes - providers and clients will not have legal recourse provided in licensed homes - precludes use of certain funding only available in licensed homes - may not be feasible option for public agencies - may need to develop own certification process
Shared Family Care Licensure	- provides opportunity to design a licensing process to meet the specific needs of shared family care - provides the benefits of state monitoring to better protect the client from potential abuse, and the legal recourse provided to host and client families in licensed homes	- requires statutory changes which involves a lengthy, cumbersome process, and may not be possible

Insurance

In addition to licensing issues, agencies must consider insurance policies and liability issues. Each agency must decide whether to investigate the criminal history of potential host-families and whether to accept those with a record. In order to license the homes, most states require foster care providers to submit fingerprints and go through a criminal record clearance; however, some states may have an exemption process (e.g., for applicants with a criminal record). Clients often are not required to go through a criminal record clearance process, although some child welfare agencies do conduct criminal record checks on parents after determining that they have abused their children. Regardless of the thoroughness of background record checking, new problems will arise. Therefore, it is imperative to have an insurance or liability policy in place to protect both providers and clients.

Most states have some form of insurance or liability policy which protects providers and children in licensed foster care homes. Maryland, for instance, is self-insured and will cover any damages that are not covered by a licensed foster care provider's home-owners insurance. Oregon protects licensed foster care providers under a tort contract only if the foster parents are caring for dependent children without their biological parents. Therefore, to protect SFC resource parents who are certified but not licensed as foster care providers in a demonstration program in Oregon, the sponsoring agency was forced to purchase commercial liability insurance. *A New Life Program*, which also treats its mentor families as independent contractors, has a general insurance policy which covers all agency activities. Mentors, however, must carry their own home owner/renter and auto insurance, and are advised to inform their insurance agents of additional household members. Given this wide variance, each sponsoring agency should learn about their state's and agency's insurance and liability policies and explore all possibilities prior to initiating SFC, and host families should be encouraged to review their own insurance policies. It may also be possible to amend an existing state or agency policy to include SFC providers.

Financing Shared Family Care



SECTION VI

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SECTION VI

Financing Shared Family Care

Because out-of-home care for children and transitional or supportive living arrangements for adults historically have been addressed separately in this country, and because shared family care is such a new concept, financing placements of whole families in private homes will require creativity and innovative blending of funds. In some cases, for example, the child(ren) may be financed through one source (e.g., IV-E in states with waivers or county child welfare funds) and the parent(s) through another (e.g., emergency assistance or drug and alcohol funds). Implementing agencies may have to piece together financing from private foundations, community businesses or organizations, and local, state and federal public funding sources to meet the needs of their particular program. Private foundations, for instance, may provide grants for start-up costs (e.g., planners and retainers) and program evaluation, although they rarely will cover operating expenses (e.g., maintenance and administration). Implementing agencies should explore local and state funds (e.g., through the departments of social services or public welfare, mental health, public health, drug and alcohol abuse, etc.) to cover these costs. Additionally, some states have affordable housing trust funds which may be used to help renovate host families' homes or help client families with rental assistance or certain moving expenses when they leave placement.

Several federal funding streams may be also available for SFC programs. The availability and accessibility of some of these funds will vary, however, based on the population being served and individual state and local implementing plans. The structure of the program and expectations of the host and client families will also significantly influence which federal financing sources can be used for SFC. For instance, if client families are expected to purchase and prepare their own food, they should be able to retain food stamps benefits while in placement if they are otherwise eligible.

Eligibility for AFDC is a little more complicated. The "double dipping" law prohibits two different sources of federal funding to be used to support the same family. For example, general AFDC cannot be used to support a child in foster care if other federal funds (e.g., IV-E) are being accessed for that same child. However, a provision in the Social Security Act allows biological parents to continue to receive AFDC if their child is temporarily removed from their care. Although this has never been tested with whole families entering care, it may be possible to apply this provision so that families in SFC situations can retain their AFDC benefits while in temporary placement, as long as other federal funds are not being used for the same purpose. In order for clients to retain their AFDC benefits while in care, however, it may be necessary to structure SFC so that client families are, in effect, maintaining their own home (a criteria for AFDC eligibility). That is, client families in SFC would have to provide for their own basic needs and, possibly, give a portion of their monthly AFDC benefit to the host family as rent. Then, perhaps, other funding (e.g., IV-B or local, state or private funds) could be used to compensate the host family for the services they provide (e.g., mentoring, training, transportation, etc.).

The following table lists federal funding sources that may be available for SFC maintenance and services, as well as housing assistance for host families and clients transitioning out of placement. Agencies planning to coordinate shared family care for special populations may also have access to additional targeted federal funds not listed below (e.g., Housing Opportunities for People with AIDS (HOPWA) and Ryan White Care funds may be available for SFC placements of families affected by HIV, and Alcohol, Drug Abuse and Mental Health Services Block Grants for families affected by substance abuse).

Potential Funding Source	FEDERAL FUNDING SOURCES		Contact
	What It May Cover	Limitations	
Title IV-E (Foster Care Maintenance & Adoption Assistance)	- Foster care maintenance for adolescent moms w/children in SFC - Training and supervision of SFC providers - Possibly foster care maintenance for any SFC placement (or at least the child's portion) in certain states that have waivers* - Possibly administrative costs (e.g., of recruiting and licensing host families, pre-placement services and case plan development and management)	- Current law only covers children separated from their biological parents - State match required at state's Medicaid match rate for maintenance, 25% for training and 50% for administration	- State or Local Public Foster Care Agency
Title IV-B (Child Welfare Services)	- Potentially any SFC related service to families (i.e., any service related to child welfare, family preservation or family support, including assessment and improvement of court procedures) if it is included in the state plan	- Service must be included in state plan - Requires 25% state match - Limited amount of funds based on yearly Congressional appropriations (for child welfare services) and a capped entitlement (for family preservation and support)	- Local Department of Children and Family Services
Title IV-A: AFDC	- May cover SFC maintenance for eligible families if no other federal funds (e.g., IV-E) are being used for maintenance payments and clients provide for their own basic needs while in placement.	- May not be used if other federal funds are being used to maintain the family in placement, or if clients are not providing for their own basic needs.	- State or Local Department of Social Services

* Section 1130 of the Social Security Act grants the Department of Health and Human Services the authority to permit as many as ten states to conduct demonstration projects which involve the waiver of certain requirements of Titles IV-B and IV-E.

Potential Funding Source	What It May Cover	Limitations	Contact
Title IV-A: Emergency Assistance	- May cover SFC maintenance (for clients who are not otherwise eligible for AFDC) for a limited period of time not to exceed 12 months	- Depends on each state's Emergency Assistance Plan: not all states offer it; some states may not allow it to be used for SFC at all; and others may limit its use to an unrealistic time period (e.g., 30-60 days) - State must provide 50% match	- Local Department of Social Services
Title XX: Social Services Block Grant	- Will cover any social service included in state plan	- A capped entitlement (i.e., limited funds) used at the discretion of each state - most states use a majority of it for services to the elderly	- State Department of Social Services
SSI	- May be used for SFC maintenance of individual family members who are mentally or physically disabled or who have HIV. Note that SSI benefits for an individual family member should not effect the remaining family's eligibility for other benefits (i.e., other federal funding streams may still be accessed for SFC maintenance).	- Only covers the eligible individual	- Social Security Administration
Food Stamps	- Client families may be eligible for food stamps if they purchase and prepare their food separately from the host family. If the two families prepare food together, the entire household may be eligible for food stamps as a single family unit if their combined incomes (outside of any maintenance payments) meet eligibility criteria.	- If the host and client families purchase and prepare food together, the host family's income may make them ineligible. If they are eligible as one unit, their total grant will be less than that of two separate families.	- Local Department of Social Services

Potential Funding Source	What It May Cover	Limitations	Contact
Medicaid	- Targeted case management for children in SFC - Rehabilitative services (e.g., individual, group or family therapy) for families in SFC - Transportation to necessary services - Respite care or other services for certain populations (e.g., HIV infected, medically fragile children) who would otherwise be institutionalized	- Reimbursable services and eligible populations are determined by each state - Cannot duplicate payments under other federal programs (e.g., IV-B or IV-E) for the same service - Some services (e.g., respite care) may require a HCB waiver - Requires state match	- Designated State Medicaid Agency
Transitional Housing for the Homeless	- Acquisition and rehabilitation of housing for homeless families with children - Supportive services to homeless families with children <i>Note: may be used to purchase foster homes as well as transitional homes after placement</i>	- Funding level set by annual Congressional appropriation - Involves lengthy process	- Local Housing Authority
HUD Funded Programs (e.g., Community Development Block Grants (CDBG) and HOME)	- Rehabilitate, improve or reconstruct public or privately owned or rented residential facilities for low- or moderate-income people - Purchase and renovate housing - Subsidize mortgage or pay part of a down payment to expand home ownership opportunities for low- and moderate-income home buyers - Rental assistance	- Cannot be used for maintenance or ongoing expenses - Use of funds determined by local plan - Must make long-term commitment to use financed facilities for low-income persons - May involve low-interest loans (which can usually be deferred) rather than free money - Involves lengthy process - Requires a state or local match	- Local Housing Authority

Program Planning and Evaluation



SECTION VII

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SECTION VII

Program Planning and Evaluation

Shared family care is not a panacea and will not be appropriate nor effective for all families. Therefore, it should be developed as one component in a continuum of family preservation, reunification and adoption services available to families in the community. The eight step process described below should serve as a framework for designing a shared family care program.

A Planning Framework for Designing a Shared Family Care Program

1. Educate agency and community members about the potential of SFC.
2. Assess the extent of the problem and the need in the community.
3. Assess your organization's resources and desired level of involvement.
4. Define the scope of the program.
5. Identify key players and potential resources.
6. Develop a program management plan.
7. Design an evaluation plan.
 - process evaluation
 - outcome evaluation
 - evaluation of the program's effect on host families and use of social services.
8. Outreach to agency staff, community members and referring agencies.

Educate Agency and Community Members

Before an agency or community can assess the need for a new service, they must understand the basic goals, program elements and anticipated benefits of that service. Therefore, prior to developing a Shared Family Care (SFC) program, it is critical to educate all members of the agency (in all divisions), and other potential client referral sources, about the concept. Community members who should be informed about SFC include personnel in: courts, prisons, other family reunification and preservation programs, homeless shelters/programs, residential and out-patient substance abuse treatment programs, hospitals, schools, religious and other community organizations, mental health programs, and child care programs.

Assess the Extent of the Problem and the Need in the Community

After providing some preliminary information about SFC, the next step is to conduct a community needs assessment to determine the extent of the problem and document the need for an alternative service. The assessment, which does not have to be extensive, is critical in helping to garner support for SFC, to develop realistic goals and objectives, and to serve as a yardstick against which to measure change and evaluate impact. Some important information to collect, although not always available, includes:

- ◆ number of children in foster care (i.e., regular, treatment and institutional care)
- ◆ number of children waiting to be placed in foster care
- ◆ median length of stay in foster care
- ◆ number of children returning to foster care after reunification attempts
- ◆ number of families being separated due to housing problems
- ◆ extent of substance abuse among pregnant and parenting women
- ◆ extent of domestic violence
- ◆ number of families affected by HIV/AIDS
- ◆ number of homeless families

Along with documenting the need, it is important to identify what is already being done to address this need, i.e., what services are already provided. For instance, if substance abuse appears to be a problem, determine the number of residential substance abuse treatment slots available for women with children, and the length of waiting lists for these programs. Also, determine reasons for lack of access to existing resources and services if they are not being used despite an evident need. Some of this information should be available from local public and private agencies. It is also important to review the local family preservation plan and any other related local plans. Finally, the needs assessment should include a survey of agency staff and other members of the community such as: religious leaders, private direct service agency directors, school and hospital personnel, police, and other community residents.

Assess Your Organization's Resources and Desired Level of Involvement

The sponsoring agency is responsible for establishing the mission, goals and objectives of SFC, overseeing its implementation and evaluating its impact. The implementing agency is responsible for providing the service and conducting the day-to-day operations. Individuals interested in SFC must first determine if their agency is willing to assume either or both of these roles. That is, does the organization have the motivation, leadership and commitment; the financial resources; and the personnel to oversee and/or provide SFC? Public agencies may choose to sponsor SFC and contract out to private agencies to provide the service; whereas private agencies are more likely to assume both roles or simply provide the service under contract with a state or local agency. Either way, SFC should, in most cases, be subsumed under the auspices of family preservation rather than foster care.

Define the Scope of the Program

Based on results of the needs assessment, begin to define:

- ◆ a program mission, goals and objectives, which should be consistent with those of the sponsoring agency's
- ◆ the target population
- ◆ the basic design of the program (e.g., general timelines)

Identify Key Players and Potential Resources

Once a general framework for SFC has been established, it is important to identify key players who are interested in and committed to the concept. They may include other agency staff, judges, legislators, religious or other community leaders, foster parents and other potential mentors, public housing authorities and non-profit housing developers, child welfare professionals, hospital staff and local funders. Their support is critical in identifying financial resources, potential host families and clients, and in understanding relevant zoning and licensing regulations. The sponsoring agency should use these informants and the information available to determine how to license SFC homes and how to pay for SFC maintenance and related services. It may also be helpful to consult with a local legal aid attorney and/or a local expert in public welfare eligibility to ensure that all potential public funding streams are explored, and to address any liability issues.

Develop a Program Management Plan

Developing a program management plan involves:

- ◆ Establishing specific client eligibility criteria
- ◆ Determining which services will be provided by the agency, the mentor, and other community organizations
- ◆ Determining personnel needs and a system for hiring and training staff
- ◆ Developing personnel policies and procedures
- ◆ Determining if and how the mentor homes will be licensed, and working with the appropriate licensing agency or developing certification criteria and procedures
- ◆ Setting provider reimbursement rates and developing a budget
- ◆ Developing program policies and procedures (e.g., house rules and consequences of breaking rules, abuse reporting, confidentiality, storage, visitation, discharge criteria, etc.)
- ◆ Developing a plan for recruiting, hiring, training, supervising and supporting host families
- ◆ Developing a referral system for clients
- ◆ Developing methods for assessing clients
- ◆ Establishing guidelines for working with relatives not in placement

Design an Evaluation Plan

Ongoing program monitoring and comprehensive evaluation are essential in order to fully explore the utility and effectiveness of shared family care (SFC). Monitoring helps to determine if the program is being implemented as planned and reaching the target population, and it helps to identify needed changes and plan effectively for the future. Evaluation measures program outcomes and effectiveness against established goals and criteria. Evaluation results are also useful for long-term planning and provide timely information to potential funders, legislators, administrators, and providers. Each agency sponsoring SFC should use the following guidelines to develop an evaluation strategy prior to placing any family in SFC. Agencies may choose to work with an evaluation consultant or a local university or college to assist in the design and implementation of an evaluation plan. Potential clients, mentors and community members should also be involved in designing the evaluation plan and the necessary documentation forms.

Any evaluation process should begin with:

- ◆ a clearly stated purpose of the evaluation (note: the exact purpose of SFC may vary depending on the auspices and funding);
- ◆ a knowledge of the targeted audience or stakeholders (e.g., funders, legislators, administrators); and
- ◆ a specific formulation of realistic, measurable program goals, objectives and activities that address the concerns of stake holders.

Clarifying these issues at the outset will help ensure that sufficient, useful information is collected without overburdening program participants with cumbersome assessments and surveys which generate information that is never used. A comprehensive evaluation plan should include three components: (a) process evaluation; (b) client impact or outcome evaluation; and (c) evaluation of the program's effect on host families and social service patterns. Some evaluations, however, may be limited to process evaluation because of local constraints or because an impact evaluation is premature.

PROCESS EVALUATION

Process evaluation involves ongoing, routine monitoring of a program's activities and should consider:

- ◆ number of families served
- ◆ demographic and psychosocial characteristics of client and host families
- ◆ number and sources of client referrals
- ◆ reasons for client participation
- ◆ number of mentor applicants and sources of their referral
- ◆ reasons for mentor participation
- ◆ description and frequency of services provided
- ◆ length of clients' stays in placement
- ◆ level, frequency and content of training and supervision provided to mentors
- ◆ client, mentor, and staff opinions about what works and does not work

Each agency should develop formal mechanisms for collecting and processing this information on a regular basis. Methodology should include collection of both quantitative and qualitative information. Quantitative data can be collected through standard forms (e.g., client intake forms, individualized family plans, team meeting reports, and mentor applications) and consistent documentation by staff of all contact with clients and host families (see Appendix B8 for sample documenting and reporting forms). This information should be collected on an ongoing basis and reported and reviewed quarterly. Qualitative information can be collected informally on an ongoing basis through mentor group meetings. In addition, formal interviews with staff, clients, and host families should be conducted at least once a year, and a standard "exit interview" should be conducted with each client that leaves or graduates from the program.

CLIENT IMPACT OR OUTCOME EVALUATION

Ideally, to determine the impact of SFC on client families, the evaluation should include a comparison group (e.g., families who receive traditional foster care or family preservation services, who can also comment on their experiences). If this is feasible, it may be necessary to have all participating families sign a consent form. With or without a control group,

however, the impact evaluation should consider long- and short-term outcomes of the client families. Administrative data can also provide comparison families and track their placement outcomes for comparison to children in SFC families. Although specific outcome objectives will vary depending on the goals of each SFC program and the clientele being served, the same information should be collected at intake, discharge, and on a pre-determined schedule during and after placement. To the extent possible, this information should be collected from multiple informants (e.g., clients, mentors and staff). Additionally, agencies should attempt to choose objectives which are realistic and sensitive to change. Following are some standard outcomes that agencies may consider measuring.

Short-term outcomes:

- ◆ Parent's improved psychosocial and emotional well-being and feelings of self-worth
- ◆ Parents' increased ability to meet their child(ren)'s physical and emotional needs
- ◆ Family's ability to remain together or be reunited
- ◆ Parent's increased ability to make good decisions for the family
- ◆ Parent's increased access to and use of community resources
- ◆ Family's progress toward achieving the goals in their individualized plans (which may address issues related to substance abuse, domestic violence, permanency planning or other personal issues)
- ◆ Child(ren)'s improved physical, emotional, educational and psychosocial development

Long-term outcomes:

- ◆ Sustained progress on short-term goals (mentioned above)
- ◆ Parent's increased ability to live independently (e.g., secure and maintain housing and employment)
- ◆ No new child abuse or neglect reports or entry/re-entry into foster care system

Agencies may design their own instruments or use existing tools to assess identified outcomes. To measure change in parents' interaction with their children, for example, agencies can develop a checklist of appropriate parenting behaviors for mentors to use as they

observe families interacting in their homes (see Appendix B9 for a sample *Daily Report for Resource Parents* instrument developed by the Oregon Social Learning Center). Mentors should be asked to complete this list every day for the first two weeks of each placement in order to create an accurate baseline; for several days every three months thereafter; at placement termination; and at six and twelve months after placement termination. To make this information useful, agencies must establish an objective method for analyzing the data and documenting change. Staff can use this same instrument to observe parent/child interaction through videotapes of parents and children playing together, either in the office, at home, or in some convenient location (e.g., a park).

Additionally, parents can be asked to report on their own responses to certain behaviors of their children using a simple daily report form. This form should list certain child behaviors and ask the parents to indicate whether each behavior occurred and how they responded. Obviously, different forms should be developed for children of different ages to reflect appropriate behaviors. (See Appendix B10 for a sample *Parent Daily Report on Five-Year-Olds* developed by the Oregon Social Learning Center.) Information from these surveys can be compared with observations of staff and mentors to get the most accurate assessment of parent/child interaction.

Numerous standardized instruments also exist to measure various factors related to family functioning, parenting ability, personal issues, psychosocial well-being, infant/child development and social/life skills (see list in Appendix D). The Child Abuse Potential Inventory (Milner, 1986), for example, may be used to assess a parent's risk for abusing her child. The following standard instruments may also be useful in assessing parents' emotional and psychosocial well-being: the Beck Depression Inventory (Beck et al., 1961), the Hudson Index of Self-Esteem (Hudson, 1982), and the Maternal Self-Report Inventory (Shea and Tonick, 1988). Additionally, SFC programs serving clients affected by substance abuse may also administer the Addiction Severity Index (ASI) to assess changes in clients' substance use and related psychosocial areas. Standardized instruments should all be conducted by trained staff at intake; at three month intervals while in placement; at placement termination; and at six, twelve and 24 months after placement. Agencies may also consider surveying clients at placement termination to determine their satisfaction with the services provided. These surveys can be adapted from existing instruments, e.g., Magura and Moses' (1986) Parent Outcome Interview, or DeLoayza & Salsberg's (1982) Client Satisfaction Inventory.

EFFECT ON HOST FAMILIES AND USE OF SOCIAL SERVICES

Evaluation of SFC should also measure the program's impact on participating host families and their use of social services. Agency staff or an independent evaluator should interview mentors when they join the program, annually, and when they leave, to determine:

- ◆ characteristics associated with retention
- ◆ reasons for leaving
- ◆ changes in mentors' feelings of competency, self-worth and empowerment
- ◆ mentors' satisfaction with the program and the implementing agency

Additionally, to determine the extent to which the community is knowledgeable of SFC and views it as a viable service, agencies should track the sources and number of client and mentor referrals to the program. Client families that remain intact during SFC placement should also be tracked after leaving placement to determine the extent to which they remain together and avoid future involvement with the social service system. To further assess the effect of SFC on the child welfare system, agencies should compare quantitative data on subsequent child abuse and neglect reports and foster care entries for families which received SFC and those which received other out-of-home and family preservation services in order to detect general program performance. Most of this information should be available from the local department of social services or other public agencies.

SFC is unlikely, at first, to significantly affect local rates of homelessness, unemployment and other indicators of community well-being. Therefore, rather than setting unattainable evaluation goals, agencies are advised to measure the outcomes of individuals served by SFC (i.e., host and client families), and the extent to which SFC is provided by community members and used by families from the community, rather than indicators of overall community health.

Outreach to Agency Staff, Community Members and Referring Agencies

As a new service, it is critical to continuously educate all members of the implementing agency (in all divisions), and all possible referring agencies, about SFC so they recognize it as an initial alternative service for certain clients, rather than a last resort. Also, in order to ensure sufficient and appropriate referrals to SFC, staff from the implementing agency should continue to educate and collaborate with potential referral sources, e.g., courts, prisons, other family reunification and preservation programs, homeless shelters/programs, residential and out-patient substance abuse treatment programs, hospitals, schools, religious and other community organizations, mental health programs, and child care programs.

Conclusion



SECTION VIII

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SECTION VIII

Conclusion

Important innovations in child welfare services take time to develop and become widely available. Treatment foster care has existed as a service option for children in this country for over twenty years, but has only become widely available in the last few years. Intensive family preservation has finally become a mainstream service option available for families at risk of losing their children through the child welfare system. Yet, service providers often are still forced to choose between services which "protect the child" and those which "preserve the family." Shared family care promises to narrow the gap between these two paradigms by addressing both goals simultaneously. It is, therefore, likely to become a standard service option in the field.

These *Shared Family Care Guidelines* are designed to inform readers of this new service option and provide a framework for incorporating it into the standard continuum of services available to families. As with any new program, challenges will inevitably present themselves throughout the planning process. Some challenges to be particularly aware of include:

- ◆ garnering community and agency support of the program and involvement in its development
- ◆ securing funds for planning, operating and administrative expenses, and evaluation
- ◆ recruiting and retaining host families
- ◆ getting clients referred for shared family care
- ◆ establishing measurable, attainable program objectives
- ◆ developing an evaluation plan *before* clients receive services

This manual should identify the key elements to consider in developing shared family care and offer some guidance in avoiding known obstacles or barriers so program developers can spend their energy overcoming new barriers as they arise.

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Appendices



A. Client/Service Matrix

B. Sample Forms and Program Materials

C. Discussion Points for Legislators and Administrators
with Estimated Program Cost Comparisons

D. List of Possible Evaluation and
Assessment Instruments

APPENDIX A

Client/Service Matrix

The following list of needs and program components is not necessarily comprehensive, nor will it necessarily apply to every client with the corresponding characteristic. Also the program components identified are intended as additions to the basic elements of any shared family care program, and none of the categories is mutually exclusive. Finally, each program has to decide which of the identified services will be provided by agency staff, host families and/or through referral to other agencies.

CLIENT/SERVICE MATRIX					
Client Characteristic (Primary Reason for Participation)	Client Needs	Specific Program Components	Anticipated Client Outcomes	Training for Mentors	Financial Sources
Drug or alcohol addiction	- substance abuse treatment - recovery support - parenting skills - healthy routines and eating & sleeping habits - proper health care - mental health counseling - positive socialization skills - education and/or vocational skills - employment - sober housing	- out-patient substance abuse treatment - recovery support - assistance maintaining abstinence and identifying and attending self-help groups - developmental screening and necessary early intervention services for infant/ child - parenting education - assistance in meal preparation, planning ahead, establishing routines and understanding consequences - assistance establishing a new, sober support network and obtaining sober housing - HIV screening and prevention - life skills training	- complete substance abuse treatment program - continual participation in self-help programs - development of appropriate daily routines - improved parenting skills and bonding with child - improved development of infant or child - improved self-esteem and emotional well-being - development of sober support network - transitional or permanent sober housing	- all aspects of substance abuse, recovery and relapse - effects of prenatal substance abuse - prevention of HIV and STDs - working with male partners and other extended family members - infant/child development	- Alcohol and Drug Abuse Block Grants - state and local drug and alcohol funds - AFDC

Client Characteristic (Primary Reason for Participation)	Client Needs	Specific Program Components	Anticipated Client Outcomes	Training for Mentors	Financial Sources
Homeless or in need of adequate housing	- resources - housing - permanence - routine - appropriate dress and grooming habits - education and/or vocational skills - employment	- linkage with community resources - assistance obtaining federal benefits - help establishing a daily routine & maintaining a home - education/vocational training - help communicating with schools and keeping child in school (if school age) - budgeting and money management - referral for routine medical services - mental health counseling - assistance developing appropriate dress and personal grooming habits	- use of community resources - transitional or permanent housing - financial & emotional support network - child's consistent school attendance and improved school performance - registered to vote - improved self-esteem and emotional well-being - enrolled in educational or vocational program and/or obtained job	- nature of homelessness - substance abuse and recovery support - federal entitlements and other financial assistance - community service & housing resources - knowledge and prevention of infectious diseases	- Transitional Housing for the Homeless - State or local homeless funds - Possibly other McKinney funds administered through DHHS or HUD - Title IV-A Emergency Assistance or other state or local emergency assistance funds - Section 8 or other low-income housing programs - AFDC

Client Characteristic (Primary Reason for Participation)	Client Needs	Specific Program Components	Anticipated Client Outcomes	Training for Mentors	Financial Sources
Discharged from prison or some other correctional facility	- reunification with child - reintegration into community - resources and support - daily routines and general housekeeping - education and/or vocational skills - employment or financial assistance	- linkage with community resources - assistance obtaining federal benefits (e.g., AFDC) - establishing a daily routine and maintaining a home - education, vocational training and/or employment assistance - budgeting and money management - parenting education - assistance understanding consequences	- reunification with child(ren) - adequate parenting skills - use of community resources - transitional or permanent housing - financial and emotional support network - registered to vote - improved self-esteem and emotional well-being - enrolled in educational or vocational program and/or obtained job - cooperation with probation plan	- working with probation officers and the court system - substance abuse and recovery support - federal entitlements and other financial assistance - community service and housing resources - knowledge and prevention of infectious diseases	- Title IV-B family preservation/support - Title IV-A Emergency Assistance - AFDC

Client Characteristic (Primary Reason for Participation)	Client Needs	Specific Program Components	Anticipated Client Outcomes	Training for Mentors	Financial Sources
Chronic or acute illness or disability (e.g., HIV)	- intermittent assistance providing basic care for child(ren) - assistance getting to medical appointments - healthy meals and assistance preparing them - emotional support - development of permanent custodial plans for child(ren)	- transportation to medical appointments - emotional support and mental health counseling for all family members - preparation of meals and/or nutrition counseling - intermittent care of child - minimal assistance with medical care - legal counseling - help arranging hospice care - assistance with permanency planning	- improved emotional well-being of parent and child - development of permanency plan for child(ren) - adequate care of child	- understanding physical and emotional aspects of HIV/AIDS - medical services in community - legal, social and logistical aspects of permanency planning - nutritional needs for people with HIV - confidentiality	- Medicaid - Ryan White Care funds - Housing Opportunities for People with AIDS - state or local AIDS funds - SSI and SSDI
Transition from domestic violence shelter or situation	- safety - security - financial assistance - mental health counseling (for parent and child) - employment - legal assistance - safe, permanent housing	- confidentiality - mental health counseling (for parent and child) - support groups - legal counseling - assistance locating safe housing - assistance obtaining federal benefits (e.g., AFDC and food stamps) - referral for medical care	- safety of parent and child(ren) - improved self-esteem and emotional and psychological well-being of parent and child - move to safe, permanent home - obtain temporary financial security through public assistance and/or employment	- dynamics and impact of family violence - federal entitlements - child development - confidentiality - legal resources - physical, emotional and sexual abuse	- Title IV-B family preservation/support - National Clearinghouse on Child Abuse and Neglect - state or local domestic violence funds - Title IV-A or local emergency services - Title XX - AFDC

SHARED FAMILY CARE PROGRAM GUIDELINES

Client Characteristic (Primary Reason for Participation)	Client Needs	Specific Program Components	Anticipated Client Outcomes	Training for Mentors	Financial Sources
Trying to regain custody of child (i.e., in family reunification program)	- appropriate parenting skills - support - child safety - daily routines - social support network	- parenting training - assistance in developing and maintaining daily routines - linkage with community resources - careful monitoring of parent/child interaction - mental health counseling for parent and child(ren) - assistance developing coping skills	- improved coping and parenting skills - safety of child - family reunification with no subsequent abuse/neglect reports - improved emotional and developmental well-being of child - established social support network	- dynamics and effects of child abuse/neglect - teaching and modeling parenting skills without taking over - communicating with foster parents and extended family members - working with the courts and foster care system	- Title IV-B family preservation/support - Title IV-E with waiver
Recent child abuse or neglect report (e.g., alternative to foster care or family preservation)	- appropriate parenting skills - support - child safety - daily routines - social support network	- parenting training - assistance in developing and maintaining daily routines - linkage with community resources - careful monitoring of parent/child interaction - mental health counseling for parent and child(ren) - assistance developing coping skills - developmental assessment of child and referral for necessary intervention services	- improved coping and parenting skills - safety of child - no subsequent abuse/neglect reports - family remains together - improved emotional and developmental well-being of child - established social support network	- dynamics and effects of child abuse/neglect - teaching and modeling parenting skills without taking over - communicating with foster parents and extended family members - working with the courts and foster care system	- Title IV-B family preservation/support - Title IV-E with waiver

APPENDIX B

Sample Forms and Program Materials



MINNESOTA HSA
► Innovative Community-Based Foster Care
 Minnesota South Carolina Texas

**MN Human Service Associates
 Fostering Whole Families Program
 Rights and Responsibilities Agreement**

between _____ and _____.

Participant Family

- 1) This program is about helping you and your children get to where you want to be. Set goals for yourself and your children in 3 areas: taking care of yourself, meeting the physical and emotional needs of your children, and connecting to resources to help with self care and care of your children. Come prepared to discuss your goals and progress toward reaching them in goal setting and review meetings with the placement team. Meeting your goals means that you complete the program and are ready to move on.
- 2) State to the host family how she/he can help you meet your goals, involve them in your goal setting, and let them know if they are doing something that is not helpful for you. Sit down weekly with hosts to talk about how it's going and what you need from them. Do not isolate yourself under stress!
- 3) Respect the rights, values, and possessions of the host family, as the same respect from the host family is your right. Know that theft of another's possessions can be reported to legal authorities and can be grounds for asking you to leave the program.
- 4) Participate as an active family member in family decision making such as selecting and preparing food, house cleaning, and planning activities for the children.
- 5) Do not put the host or your own family at risk of danger if you have an abusive family member or friend. Talk with the host family before you invite a guest to the house. Be willing to file an Order for Protection if concerns for your or other's safety continue.

570 Asbury Street, Suite 105, Saint Paul, Minnesota 55104-1849, (612) 645-0688, Fax (612) 645-0891

Host Family Responsibilities

- 1) Assist participant families in reaching their goals by supporting and cheering on successes, sharing what has worked for you, helping to obtain community resources, and offering constructive feedback on what the family could do differently. Both families need to understand that you are mandated to report child neglect and abuse concerns onto both the HSA and county social worker.
- 2) Provide at minimum a separate bedroom with adequate furniture and storage space to assure a family's privacy. A participant family must have some place in your home which they can claim as their own.
- 3) Include the participant family in all household decisions which affect everyone: shopping and preparation of food, budgeting, division of chores, and family or community events.
- 4) Complete a monthly report documenting family's progress toward meeting their goals. Come prepared to discuss goals and strategies to help families meet them during the placement goal and review meetings with the team.
- 5) Be available to offer follow up support to the participant family after they leave your home.

House Rules Contract

(cover any bottom line rules you need to successfully live together, involving household upkeep, visitors, care and discipline of children, privacy areas, etc.)

SIGNATURES:

Host Family

Date

Participant Family

Date

**CHILDREN'S
HOME & AID
SOCIETY**

of Illinois

SAMPLE PLACEMENT CONTRACT

Any time people live together there is a potential that there will be problems. This contract is designed to make sure that everyone agrees about what is expected of them and what they can expect from other during their participation in the Adolescent Mother's Program. If one of the parties to this contract wants to change or terminate the contract, they agree to provide a formal thirty (30) day notice to each of the parties. During that thirty days, the parties will agree to meet at least twice to try to renegotiate the contract to allow the placement to continue. This contract will be reviewed within ninety (90) days.

AGREEMENTS**SHARON (ADOLESCENT MOTHER)**

- 1) Sharon agrees to assume full responsibility for all the physical and emotional needs of her daughter, including arranging for appropriate child care, arranging and keeping necessary medical appointments, and maintaining a regular daily schedule.
- 2) Sharon agrees to be willing to learn how to appropriately care for her daughter. Toward this end, Sharon will be open to advice from Stan and Cheryl (her Resource Family) and will participate in the Parents Too Soon support group in her neighborhood both to strengthen her skills as a parent and to gain support from other teens.
- 3) Sharon agrees to follow her self sufficiency plan as established.
- 4) Sharon agrees to live within the house rules which she has negotiated with Stan and Cheryl. Including regularly attending school.
- 5) Sharon agrees to discuss her reasons for any angry outburst with Stan or Cheryl after they have given her a fifteen minute "Cooling Off" period in her room.
- 6) Sharon agrees that if she is feeling a need to run away, she will talk with Stan and Cheryl or her caseworker or her CHASI worker to see if they can help her to figure out what is making her feel that way and how they can help.

- 7) If, for some reason, Sharon feels she is unable to meet some aspect of this contract (or she feels another party is not meeting their obligations under the contract), she agrees to either tell Stan or Cheryl, or will contact her caseworker or CHASI staff person to discuss renegotiating the contract.

SIGNATURE

DATE

STAN AND CHERYL (RESOURCE FAMILY)

- 1) Stan and Cheryl agree to provide a safe and supportive home for Sharon and her daughter.
- 2) Stan and Cheryl agree to try to help Sharon to develop the parenting skills she needs without being judgmental about problems she may be having.
- 3) Stan and Cheryl agree to be available to listen to Sharon's present frustrations about being a single parent and her concerns about her future.
- 4) Stan and Cheryl agree not to confront Sharon immediately when she is angry, but rather to give her time alone in her room to calm down because she has told them this is what she needs.
- 5) Stan and Cheryl agree that, if they have an issue with Sharon or with how she is parenting her daughter, they will tell her before they report the problem to her caseworker.
- 6) Stan and Cheryl agree to support Sharon's contact with her family and friends and to help her to learn how to use public transportation to visit her family.

SIGNATURES

DATE

RITA (ADOLESCENT MOTHER'S PROGRAM STAFF PERSON)

- 1) Rita agrees to help Sharon find day care for her daughter during the time she is in school.
- 2) Rita agrees to help Sharon find resources in her community to meet her and her daughter's need.
- 3) Rita agrees to be available to talk with both Sharon and Stan and Cheryl at least once a week to see how things are going and to hopefully help mediate programs, should they arise.
- 4) Rita agrees to involve Sharon in all planning decisions that affect Sharon and her daughter.
- 5) Rita agrees to discuss with Sharon any information which she intends to report to DCFS and/or the court regarding Sharon's progress and her ability to care for herself and her child.

SIGNATURE

DATE

JOHN (DCFS WORKER)

- 1) John agrees to support Sharon's placement with Stan and Cheryl.
- 2) John agrees to involve Sharon in all planning decisions which affect Sharon and her daughter and to invite her to her administrative case review.
- 3) John agrees to request a special clothing voucher to replace clothing lost when Sharon moved from her last placement.

SIGNATURE

DATE

MRS. B. (SHARON'S MOTHER)

- 1) Mrs. B. agrees to support Sharon's placement with Stan and Cheryl.
- 2) Mrs. B. agrees to have Sharon visit her once a week.
- 3) Mrs. B. agrees to help Sharon with developing independent living skills, including helping her to learn about grocery shopping, doing laundry and housework.
- 4) Mrs. B. agrees to be clear with Sharon about what she can and cannot do and not to make promises she can't keep.

SIGNATURE

DATE

JAMES (THE BABY'S FATHER)

- 1) James agrees to support Sharon's placement with Stan and Cheryl.
- 2) James agrees to help Sharon get to doctor's appointments once each month.
- 3) James agrees to contribute \$25.00 a week to the baby's care.
- 4) James agrees to visit his child every Saturday from 2 p.m. to 5 p.m. and to call in advance to cancel if he can't come.

SIGNATURE

DATE

MN Human Service Associates, 570 Asbury St., Ste. 105, St. Paul, MN 55104, (612) 645-0688

PLACEMENT PLAN - YEAR _____ (1,2,3,4, ETC)

Date of Placement: _____ Date of Plan: _____
Review Dates: _____; _____; _____ Next Review Date: _____

CHILD/FAMILY INFORMATION:

Name: _____
Date of Birth: _____ Age: _____ Heritage: _____
Place of Birth: _____
County Case #: _____ Legal Custody: _____

FOR WHOLE FAMILY PLACEMENT - ADDITIONAL:

Name: _____ DOB: _____
Name: _____ DOB: _____
Name: _____ DOB: _____

BIRTH/EXTENDED FAMILY INFORMATION

Name: _____ Relationship: _____ Phone #: _____
Address: _____
Name: _____
Relationship: _____ Phone #: _____
Address: _____

HSA FOSTER/HOST FAMILY:

Phone #: _____

REFERRING AGENCY INFORMATION/FINANCIAL RESPONSIBILITY:

Agency Having Financial Responsibility: _____

County Worker/Probation Officer: _____

Address: _____

Phone #: _____

Supervisor: _____

Phone #: _____

HSA SOCIAL WORKER AND SUPERVISOR:

Social Worker: _____

Phone #: _____

Supervisor: _____

Phone #: _____

GUARDIAN/ADVOCATE INFORMATION:

Name: _____

Phone #: _____

Address: _____

MENTAL HEALTH WORKER/THERAPIST:

Name: _____

Phone #: _____

Address: _____

Youth/Family Name:

Date of Plan:

Page:

PLACEMENT CHECKLIST/DATES:

Privacy Statement Signed:

Tribal Notification Sent:

Parent Orientation:

Family Case Plan in File:

Order of Placement Preference Followed? If not, why not?

BACKGROUND DATA: *(Update Annually)*

REASON FOR PLACEMENT/CONTINUED PLACEMENT IN TREATMENT CARE:

(Update Annually)

**SUMMARY OF RELEVANT PSYCHOLOGICAL, NEUROLOGICAL, PHYSIOLOGICAL,
EDUCATIONAL INFORMATION:** *(Update as needed)*

STRENGTHS: *(Update Annually)*

AREAS OF CONCERN: *(Update Annually)*

PERMANENCY PLAN:

DATE SET:

READINESS FOR NEXT STEP:

For Child/WFP:

For Biological/Adoptive Family:

For County System:

ANTICIPATED PLACEMENT COMPLETION DATE:

Youth/Family Name:

Date of Plan:

Page:

AUTHORIZATION OF FUNDS FOR THE FOLLOWING SERVICES

AUTHORIZED AMOUNT

DAY CARE:

TRANSPORTATION:

CLOTHING ALLOWANCE:

RECREATION:

OTHER:

LIST OF CONTACTS: (SINCE LAST REVIEW: _____)

(In between the 3rd quarter review and New Placement Plan)

(i.e., home visits, phone contacts, support group attendance)

LIST OF CONTACTS: (QUARTER #1)

(i.e., home visits, phone contacts, support group attendance)

LIST OF CONTACTS (QUARTER #2)

(i.e., home visits, phone contacts, support group attendance)

LIST OF CONTACTS: (QUARTER #3)

(i.e., home visits, phone contacts, support group attendance)

MEDICAL:

(Yearly Exam Date)

DENTAL:

(Six Month Exam Date)

Youth/Family Name:

Date of Plan:

Page:

PLACEMENT GOALS

(Always include Emotional/Behavioral and Family/Community Connections)

I. GOAL AREA:

Goal Completed

Date/Initials

PLACEMENT GOAL:

INDICATORS OF PROGRESS:

TASKS:

NARRATIVE UPDATE (Since Last Review: _____) **DATE:** _____
(Between the 3rd Quarter and New Placement Plan)

NARRATIVE UPDATE (Quarter #1) **DATE:** _____

NARRATIVE UPDATE (Quarter #2) **DATE:** _____

NARRATIVE UPDATE (Quarter #3) **DATE:** _____

Youth/Family Name:

Date of Plan:

Page:

PLACEMENT GOALS

(Always include Emotional/Behavioral and Family/Community Connections)

II. GOAL AREA:

Goal Completed

Date/Initials

PLACEMENT GOAL:

INDICATORS OF PROGRESS:

TASKS:

NARRATIVE UPDATE (Since Last Review: _____) **DATE:** _____

(Between the 3rd Quarter and New Placement Plan)

NARRATIVE UPDATE (Quarter #1) **DATE:** _____

NARRATIVE UPDATE (Quarter #2) **DATE:** _____

NARRATIVE UPDATE (Quarter #3) **DATE:** _____

Youth/Family Name:

Date of Plan:

Page:

PLACEMENT GOALS

(Always include Emotional/Behavioral and Family/Community Connections)

III. GOAL AREA:

Goal Completed

Date/Initials

PLACEMENT GOAL:

INDICATORS OF PROGRESS:

TASKS:

NARRATIVE UPDATE (Since Last Review: _____) **DATE:** _____

(Between the 3rd Quarter and New Placement Plan)

NARRATIVE UPDATE (Quarter #1) **DATE:** _____

NARRATIVE UPDATE (Quarter #2) **DATE:** _____

NARRATIVE UPDATE (Quarter #3) **DATE:** _____

Youth/Family Name:

Date of Plan:

Page:

PLACEMENT GOALS

(Always include Emotional/Behavioral and Family/Community Connections)

IV. GOAL AREA:

Goal Completed

Date/Initials

PLACEMENT GOAL:

INDICATORS OF PROGRESS:

TASKS:

NARRATIVE UPDATE (Since Last Review: _____) **DATE:** _____
(Between the 3rd Quarter and New Placement Plan)

NARRATIVE UPDATE (Quarter #1) **DATE:** _____

NARRATIVE UPDATE (Quarter #2) **DATE:** _____

NARRATIVE UPDATE (Quarter #3) **DATE:** _____

SHARED FAMILY CARE PROGRAM GUIDELINES

Youth/Family Name:

Date of Plan:

Page:

PLACEMENT PLAN

DATE:

HOW WAS YOUTH/FAMILY INVOLVED:

PROGRESS TOWARD PERMANENCY:

DOES PLACEMENT CONTINUE TO BE APPROPRIATE FOR TFC? YES NO
COMMENTS?

QUARTERLY REVIEW (Quarter #1)

DATE:

HOW WAS YOUTH/FAMILY INVOLVED?

PROGRESS TOWARD PERMANENCY:

DOES PLACEMENT CONTINUE TO BE APPROPRIATE FOR TFC? YES NO
COMMENTS?

QUARTERLY REVIEW (Quarter #2)

DATE:

HOW WAS YOUTH/FAMILY INVOLVED?

PROGRESS TOWARD PERMANENCY:

DOES PLACEMENT CONTINUE TO BE APPROPRIATE FOR TFC? YES NO
COMMENTS?

QUARTERLY REVIEW (Quarter #3)

DATE:

HOW WAS YOUTH/FAMILY INVOLVED?

PROGRESS TOWARD PERMANENCY:

DOES PLACEMENT CONTINUE TO BE APPROPRIATE FOR TFC? YES NO
COMMENTS?

Youth/Family Name:

Date of Plan:

Page:

PARTICIPANTS IN PLAN

DATE:

The following persons were present and signed this document. If absent, please state reason.

_____ Youth/Family in Placement	_____ Date
------------------------------------	---------------

_____ Family of Origin	_____ Date
---------------------------	---------------

_____ HSA Care Providers	_____ Date
-----------------------------	---------------

_____ Referring Agency Social Worker	_____ Date
---	---------------

_____ HSA Social Worker	_____ Date
----------------------------	---------------

_____ Therapist Counselor	_____ Date
------------------------------	---------------

_____ Guardian	_____ Date
-------------------	---------------

_____ Advocate	_____ Date
-------------------	---------------

_____ Educational Staff	_____ Date
----------------------------	---------------

_____ Other	_____ Date
----------------	---------------

_____ Other	_____ Date
----------------	---------------

CONTINGENCY PLAN

DATE:

1. CHILD/FAMILY'S NAME:

2. CARE PROVIDER'S NAME/ADDRESS/TELEPHONE #:

EXPECTED PROBLEM AREAS	GENERAL SOLUTIONS

3. THE FOLLOWING PERSON(S) SHOULD BE CALLED WHEN CHILD IS SUICIDAL, RUNNING, DESTRUCTIVE, OR HARMFUL TO SELF OR OTHERS:

HSA Social Worker:

Phone:

Referring Agency:

Phone:

Family of Origin/Guardian:

Phone:

Therapist:

Phone:

Other:

Phone:

4. EMERGENCY SERVICES:

Fire Dept.:

Phone:

Police Dept.:

Phone:

Hospital:

Phone:

Doctor's:

Phone:

Poison Control:

Phone:

MN HSA 24 Hour Answering Service: (612) 645-0688

5. RESPITE FAMILY NAME/ADDRESS/PHONE:

6. OPTIONAL EMERGENCY PLACEMENT:

7. SCHOOL PROGRAM (Name/Address/Contact Person/Phone):

CRIME PREVENTION ASSOCIATION

*Home and Safety Requirements***MENTORS:**

The home and safety requirements shown below are designed for use in approving and re-approving Mentors. By your signature on the *Agreement For Care and Supervision of Clients of "A New Life" Program*, you certify that your home complies with these requirements and agree to assure that such compliance will be maintained throughout your tenure as a Mentor.

MENTOR FAMILY HOME ("PREMISES")**A. Mentor's home shall contain the following:**

- 1) at least one flush toilet, one wash basin, and one bath or shower with hot and cold running water;
- 2) an operable heating system; and
- 3) an operable telephone.

B. Sleeping areas must meet the following criteria:

- 1) no unsuitable area such as a hall, stairway, unfinished attic or basement, garage, bathroom, eating area, closet, shed, or detached building may be used as a sleeping area for clients;
- 2) each client must be provided with a clean mattress and clean linens, blankets, and pillow; and
- 3) Infants must be provided with a crib or bassinet, linens and blankets.

SAFETY REQUIREMENTS

- A. Containers of poisonous, caustic, toxic, flammable, or other dangerous material kept in the home must be distinctly marked or labeled as hazardous and stored in locked areas.

- B. Emergency telephone numbers, including those for fire, police, poison control, and ambulance, must be conspicuously posted adjacent to all telephones.
- C. Fireplaces, fireplace inserts, and wood and coal burning stoves, if allowed by local ordinance, must be securely screened or equipped with protective guards. Any free standing space heaters must be used in accordance with the manufacturer's specification for operation.
- D. A smoke detector must be placed on each level of the residence. The detector must be maintained in operable condition at all times.
- E. A portable fire extinguisher, suitable for Class B fires, must be available in the kitchen and other cooking areas. The extinguisher must be tested yearly or have a gauge to ensure adequate pressure.
- F. Exposed electrical wires are prohibited.
- G. Drinking water from a noncommunity water source must be potable as determined by annual inspection.

CRIME PREVENTION ASSOCIATION
of Philadelphia
A NEW LIFE PROGRAM
R.W. Brown Community Center
1701 North Eighth Street
Philadelphia, PA 19122

MENTOR APPLICATION

NAME: _____ HOME PHONE# _____
ADDRESS: _____
CURRENT EMPLOYER: _____ WORK PHONE# _____
ADDRESS: _____
OTHER SOURCES OF INCOME: _____

BACKGROUND INFORMATION

DATE OF BIRTH: _____ S.S.# _____
PLACE OF BIRTH: _____
HIGHEST LEVEL OF EDUCATION: _____
PREVIOUS VOLUNTEER OR WORK EXPERIENCE: _____

CURRENT HEALTH STATUS: _____

GIVE A BRIEF STATEMENT AS TO WHY YOU ARE INTERESTED IN BECOMING A
MENTOR FOR THE NEW LIFE PROGRAM: _____

DISCUSS YOUR UNDERSTANDING OF INTEREST IN AND INVOLVEMENT WITH
FEMINISM, WOMEN'S LIBERATION OR WOMEN'S ISSUES: _____

LIVING ARRANGEMENTS

HOUSE ☐ APARTMENT ☐ OWN ☐ RENT ☐ # of Rooms _____ # of Bedrooms _____

HOUSEHOLD COMPOSITION: NAME AGE RELATIONSHIP TO YOU

(List all in Household)

(Attach additional sheet if necessary)

REFERENCES

LIST 3 CHARACTER REFERENCES. (THESE SHOULD BE UNRELATED TO YOU, AND SHOULD HAVE KNOWN YOU FOR AT LEAST 3 YEARS.)

NAME	ADDRESS	PHONE #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

LIST 2 EMPLOYMENT REFERENCES (if applicable):

_____	_____	_____
_____	_____	_____
_____	_____	_____

MAY CPA contact your Character and Employment Reference? Yes ☐ No ☐
 (if No why not)

 Applicant's Signature

 Date

MENTOR EMPLOYMENT CONTRACT

CRIME PREVENTION ASSOCIATION

Agreement for Care and Supervision of A New Life Clients

1. Terms of Agreement

- A. The parties of this agreement are the Crime Prevention Association, Inc., hereinafter called "CPA", of 311 South Juniper Street, Philadelphia, Pennsylvania, 19107 and _____, Mentor, hereinafter called "Mentor."

Whereas CPA operates a community-based program that provides twenty-four (24) hour supervision and treatment to drug-addicted women and their infants (hereinafter called client), CPA and Mentor (subject to the applicable regulations and control of governmental jurisdictions) do hereby enter into an agreement in which the Mentor agrees to provide the client with supervision and living accommodations. These living accommodations, herein called "premises", and located at _____ are owned and/or occupied by the Mentor.

- B. CPA agrees to pay, and Mentor agrees to accept, the sum of \$ _____ (\$ _____ per _____), as reimbursement for the Mentor's services and expenses so long as Mentor maintains satisfactory compliance with the provisions of this agreement under Section 1, "Terms of Agreement," Section 2, "Statement of Scope of Work," and Attachments I and II of Section 2. Mentor agrees to provide care and supervision for an additional client per the terms of this agreement, when the original client moves out.

- C. If Mentor is married, her/his spouse must agree to the terms of this agreement and must indicate her/his agreement by co-signing below.

- D. Due to the close client supervision requirements of this program, as outlined elsewhere in this agreement, the Mentor as primary care provider may not maintain or accept employment or engage in other business activity without the expressed written permission of the Project Director of A NEW LIFE. Documentation will be required from the employer attesting to Mentor flexibility to meet client needs.

- E. The terms of this agreement shall commence on the _____ day of _____, 199__, and shall continue until this agreement is mutually or unilaterally terminated, or until the client, for whatever reason, is removed from the premises, whichever occurs first. Should it be necessary to temporarily remove the client from the premises and/or provide care for client at another location, the Mentor will not be reimbursed by CPA for the period of time the client is not under Mentor's direct supervision.

F. Either party may terminate this agreement by providing the other with at least three (3) weeks written notice unless CPA removes the client from the premises for cause, or if the client removes herself from the premises for cause. CPA reserves the right to suspend all payments to the Mentor when it has been established that the cause of the client's removal was a result of 1) any physical or emotional abuse of the client by the Mentor; 2) any threat to the health, safety, morals or human rights of the client by the Mentor; 3) any abuse to the client's child as defined by the Child Protective Services Law of 1975, as amended; 4) any violation of the fulfillment of the conditions and responsibilities stated in each of the sections for this contract by the Mentor; or 5) the Mentor specifically requests the removal of the client from the premises. If it is established that the client's removal was necessitated by items 1), 2), 3), 4) or 5) of this paragraph, CPA reserves the right to immediately terminate this contract and all payments to the Mentor.

G. Mentor acknowledges by signature below her/his awareness that she/he accepts responsibility for the payment of all appropriate taxes to include self employment tax, and any other Federal, State, or local tax applicable to self-employed persons.

CRIME PREVENTION ASSOCIATION

Project Director
"A New Life" Program

Date

Mentor Date

Mentor's Spouse Date

MINNESOTA HUMAN SERVICE ASSOCIATES (HSA)

FOSTERING WHOLE FAMILIES PROGRAM

*** HOUSE RULES ***

- 1) Bedrooms are to be respected as private space.
- 2) Do not enter a closed door without knocking and receiving permission to enter.
- 3) No guest of the opposite sex in participant's bedroom.
- 4) Socializing is to be conducted in living room, den, or kitchen areas only.
- 5) No drinking permitted.
- 6) Under no circumstances will "being drunk" be acceptable for household members or guests.
- 7) No excessively loud noise, excessively loud music, or excessively loud television after 11:00 pm.
- 8) No drugs.
- 9) No overnight guests.
- 10) Lights and television are to be turned off upon leaving room.
- 11) Do not overload washer.
- 12) Ask host for directions if unfamiliar with appliances.
- 13) Treat household pet with respect.
- 14) Expect confrontation from host if participant is not working toward goals. (Tough Love)
- 15) Unplug hair dryer, hair curlers, clothes iron, etc., after each use.

- 16) Be responsible for damage done to host's home or personal property; damage as described by:
 - (1) Being beyond normal wear and tear, and
 - (2) That which is caused by participant or participant's child (children).
- 17) Host and participant will negotiate curfew for all of participant's guests.
- 18) No smoking within confines of house.
- 19) Responsible smoking is permitted.
- 20) Doors are to be locked at night, or upon leaving the house.
- 21) Permission for all long distance phone calls will be obtained from host before placing any long distance call.
- 22) Business phone calls will have priority over personal calls.
- 23) All requests for transportation will be made at least one day in advance.
- 24) All requests for baby sitting will be made at least one day in advance.
- 25) All requests for use of kitchen in order to prepare dinner for guests will be made at least one day in advance.
- 26) Participant will do own laundry including that of their child (children).
- 27) Participant is to clean own bedroom and own bathroom.
- 28) If sharing a bathroom, each person is to tidy-up bathroom after each use so that bathroom is ready for next person's use.
- 29) Weekly cleaning will be shared by participant and host.
- 30) Toys, games, books, etc. are to be picked up each night before going to bed.
- 31) In addition to playing in participant's bedroom, host is to designate specific area where child (children) may play.
- 32) Children are to play in designated areas only.

- 33) When participant has a guest, participant continues to be responsible for own child (children) as well as the children of the guest.
- 34) Participant is responsible for clean-up after participant's guest leaves.
- 35) Host and participant will share preparation of meals.
- 36) Host will notify participant before going grocery shopping so that participant may also go.
- 37) After each meal, each person will rinse off their dish, glass, silverware, or cup, and place in sink.
- 38) Participant will share in clean-up of dishes and kitchen area immediately following each meal.
- 39) No eating in any area of the house except kitchen, dining room, or breakfast room.
- 40) No in-between-meal snack refuse (pop cans, wrappers, empty snack bags, etc.) is to be left on countertops, tables, sink, floor, or stove.
- 41) If certain rooms have been cleaned or tidied-up in preparation of guest, these rooms are to remain clean until guest arrives.

ADDENDUMS:

DATED: _____

PARTICIPANT: _____

HOST: _____

HOST: _____

HSA REPRESENTATIVE: _____

A NEW LIFE

RULES AND REGULATIONS FOR CLIENTS LIVING IN MENTORS' HOMES

1. No possession, sale, or use of alcohol or illicit drugs.
2. No violence or threats of violence towards mentors or their friends, family or other household members, and no possession or use of weapons.
3. Vulgarity towards mentors or their families and friends will not be tolerated.
4. No sexual involvement with mentors, their friends, relations or other residents of their households.
5. Sharing with your mentor what happens in the program is encouraged, but names of other program participants must not be disclosed.
6. **Telephone calls:** During your first month in the mentor's home, you may only make calls to and receive calls from your sponsor (12-Step Program). Any other calls must be made during the day while at R.W. Brown. Incoming emergency calls will be taken and assessed by the mentor. You may not answer the telephone if your mentor is not at home. "A New Life" staff will be reachable by beeper in case of emergencies.

After the first month, your mentor will decide when, how often, and for how long you can use the telephone.

You may *not* give out your mentor's telephone number to *anyone* except your sponsor and the caretaker of your child(ren).

7. **Visits:** During your first month in the home, you can only receive visits from your sponsor or counselor. If your mentor is willing to take you, and your counselor approves, you may be allowed to visit your children.

After the first month, you may receive or make visits based on the prior approval of both your counselor and your mentor.

You may not have overnight visitors of either sex at any time.

8. **Curfew:** Curfew is 10:00 P.M. every night for the first month. After that, curfew is 10:00 P.M. on weeknights and 12:30 A.M. on weekends. Any exceptions to this must be approved in advance by your mentor and counselor.

9. You will *not* be given a key to your mentor's home. Therefore, you must arrange in advance with your mentor what time you will be coming back home when you go out, so that she/he will be there to let you in.
10. You must abide by all other rules of the house established by your mentor.

Any violation of the rules will be reported by your mentor to your counselor and may result in disciplinary procedures, up to and including dismissal from "A New Life" program and/or the mentoring home.

I have read the Rules and Regulations for mentoring homes and I understand the consequences associated with them. I therefore agree to abide by these guidelines.

Client's Signature

Date

Counselor's Signature

Date

Mentor's Signature

Date

A NEW LIFE PROGRAM

MENTOR JOB DESCRIPTION

Typical Tasks

- A. Mentor will help client learn independent living skills and good parenting techniques. This includes assisting client in:
- budgeting and money management,
 - shopping, meal planning and food preparation,
 - developing reasonable and positive sleeping habits,
 - maximizing integration into the community,
 - increasing positive socialization skills, in both one-to-one and group situations,
 - developing acceptable dress and personal grooming habits,
 - developing proper nutritional habits, regular meals, and acceptable mealtime behavior,
 - learning positive and healthy ways to care for her baby,
 - providing or arranging transportation to and from "A New Life" program, 12-Step meetings, and appointments,
 - obtaining regular and emergency medical treatment, and
 - all other related activities necessary for proper community integration.
- B. Attends all meetings and client reviews as required.
- C. Attends training and development sessions which may be offered regularly.
- D. Maintains records (daily log) and keeps "A New Life" staff informed of all changes in the client and/or her child.
- E. Participates in planning goals and objectives for client to work on in home, and completes all paperwork required by program.
- F. Performs all other duties assigned by "A New Life" staff.

Statement of Scope of Work

- A. The Mentor agrees to cooperate with CPA in caring and providing for the client placed in her/his care by CPA. In addition to maintaining compliance with the provisions of Section 1, "Terms of Agreement," Mentor will function in a manner consistent with the tasks contained in the "Mentor Job Description" (Attachment I).
- B. The Mentor agrees to provide adequate furnishings for all rooms in the premises, to maintain all furnishings in good condition, and to replace them from time to time, as needed.
- C. The Mentor agrees to live in the premises, to maintain the premises in good, clean, safe, and adequately heated condition, and to provide all utility services. Premises must comply with all provisions of the "Home and Safety Requirements List" (Attachment II).
- D. The Mentor is responsible for purchasing food, at her/his own expense for each CPA client living in the premises, unless Food Stamps are part of the client's Public Assistance support. All other provisions for the client may be procured by the Mentor only after a written request for said provisions has been submitted to and approved by CPA.
- E. The Mentor agrees to report immediately to CPA, any changes in her/his health, family or household composition, situation or other circumstances which were initially reported to CPA on Mentor's application or during the Mentor interview process.
- F. Mentor agrees that, no more than 30 days prior to the date of this agreement, she/he will obtain, at her/his expense, certification from a licensed physician that she/he has no communicable diseases or physical conditions that might endanger the health or safety of client or prevent Mentor from performing her/his responsibilities per the terms of this agreement.
- G. The Mentor agrees to indemnify CPA for all personal injuries to her/himself or her/his household, or property loss or damages to premises by the client while under the Mentor's supervision. The cost for all homeowner's/tenant's insurance and automobile insurance shall be assumed exclusively by the Mentor and shall not be the responsibility of CPA.
- H. The Mentor agrees to permit, at reasonable times as may be mutually determined by CPA and the Mentor, periodic inspections of the premises by CPA staff. "A New Life" counselors will do home visits to see their clients periodically.
- I. The Mentor agrees to contact CPA immediately to report all client emergencies which include, but are not limited to: 1) any physical or emotional illness or disturbance of client; 2) any unusual or unauthorized absence of the client from the premises; 3) any acts of unlawful behavior by the client; 4) any arrest or incarceration of the client; 5) any use of drugs or alcohol by the client; and 6) any abuse by client of her child.
- J. The Mentor agrees to keep confidential any and all information which the Mentor presently or will in the future possess concerning the client or family of the client, with the exception of the client's primary counselor, the clinical supervisor, the program director of "A New Life" or other authorized CPA official.

**A NEW LIFE PROGRAM
MENTOR DOCUMENTATION POLICY**

Mentors are required to document on client behaviors and attitudes in their homes on a daily log. This log is then submitted to "A NEW LIFE" staff and becomes part of their permanent chart. It is due to staff at the time payment contracts are due which is bi-weekly. Lack of documentation will result in the withholding of pay.

Mentors record a few sentences that describe client behaviors/attitudes specifically. "Doing well" or "fine" such as progress statements are not descriptive of specific behaviors and attitudes.

Examples of behavioral notes include:

- a) Client was resistant to talking about the schedule
- b) Client was open to my feedback about cleaning her room
- c) Client attended meeting and shared her feelings at night
- d) Client did not bathe her baby without prompting
- e) Client cooked her meals without being asked

Examples of attitudinal notes include:

- a) Client shows interest in learning to cook
- b) Client appears less motivated for going to program
- c) Client was frustrated all day when baby cried
- d) Client does not want to share her history
- e) Client gets annoyed when reminded to clean up

ADDICTIVE BEHAVIORS/ATTITUDES LIST
(negative and destructive)

"acting out" - aggressive pursuant of an addictive behavior

Manipulative Behaviors

people-pleasing - does/says what you want to hear
threatening - attempts to change your behavior
intimidating - attempts to change your behavior
agitating - tiring you out/aggravating you
fronting - presenting more positive feelings
conning - trying to get around you
whining - tiring you out, pestering
keeping crisis going - slip something past you

Isolating Behaviors

staying away from sober supports
avoiding positive people
doing activities alone
lack of interaction with you
focusing on others always
focusing on anything but themselves
lack of meaningful disclosure
focus on crisis - not telling your feelings
no disclosure of feelings, i.e., hurt, pain, sadness
sharing "credit card" feelings - now leave me alone

Dishonest Behaviors

telling half-truths - leaving out damaging information
leaving out what feedback or suggestions already given
lying about the situation
avoiding the topic altogether

Negative/Destructive Postures/Attitudes

closed and unwilling to look at own behaviors/attitudes
not wanting any feedback about staff
deflecting and talking about your need to change
shift blaming - blaming others
justifying - making excuses - not owning behavior
lack of willingness to surrender to help - never asks for help

A NEW LIFE MENTOR CASE RECORD

DAILY NARRATIVE:

Client

Mentor

SUNDAY:

/ /

MONDAY:

/ /

TUESDAY:

/ /

WEDNESDAY:

/ /

THURSDAY:

/ /

FRIDAY:

/ /

SATURDAY:

/ /

Significant Developments (Positive and Negative):

Attended M Tu W Th F

(A New Life)

Attended Su M Tu W Th F S

(12-Step Meeting)

HUMAN SERVICES ASSOCIATES

IS6: PLACEMENT TEAM MEETING REPORT

Instructions: This form is to be completed after each placement planning or quarterly review meeting.

Check one: ☐ Placement Planning Meeting ☐ Quarterly Review Meeting

1. HSA state program _____ 2. Meeting date _____

3. Name of person/family placed _____

4. Date of Birth _____

5. Name of care provider(s) _____

6. Has there been a change in the person's/family's HSA placement since the last report?

☐ No

☐ Yes (Date _____)

former HSA provider's home _____
_____)

7. Meeting location:

☐ Provider's home

☐ School

☐ Natural parent home

☐ HSA office

☐ Other (Where? _____)

8. Attending meeting?

Natural/Adoptive/Legal/Step mother

Yes No

Natural/Adoptive/Legal/Step father

Care provider #1

Care provider #2

Legally responsible social worker

HSA social worker

Youth placed

School personnel

Other service provider

SHARED FAMILY CARE PROGRAM GUIDELINES

9. Reason N/A/L/S father could not attend: _____

10. Reason N/A/L/S mother could not attend: _____

11. Total number participants _____

12. Who chaired meeting? _____
_____ HSA social worker
_____ HSA care provider
_____ Natural parent
_____ Legally responsible agency worker
_____ Person placed

13. Permanency Plan: _____
_____ None (date by which plan will be developed _____)
_____ Natural parents
_____ Relatives
_____ Adoption
_____ Foster care by another agency until emancipation
_____ Foster care by HSA until emancipation
_____ No change from previous plan

14. Date permanency plan was _____

15. Month/year for next review _____

FORM COMPLETED BY: _____

DATE _____

DATE ENTERED: _____ INITIALS: _____

DAILY REPORT FOR RESOURCE PARENT/STUDENT PARENT

(K. Kavanagh, OSLC, 1995)

Time _____ Date _____ S M T W R F S

Resource parent: Please think back over the past 24 hours. Circle the number of any of the following parenting behaviors you observed during that period.

Participant parent: Please circle all the following behaviors that you did with your child.

BEHAVIOR	EXAMPLE
1. offered encouragement	_____
2. instructed/taught the child	_____
3. used distraction in a problem situation	_____
4. showed affection	_____
5. showed frustration	_____
6. ignored the child	_____
7. played with the child	_____
8. lost temper	_____
9. threatened the child	_____
10. used physical force	_____
11. laughed with/smiled at the child	_____
12. provided comfort/security	_____
13. made clear specific requests	_____
14. followed up on child compliance	_____
with encouragement	
15. listened	_____
16. _____	_____

Nurturance/Caretaking Report

17. Describe your mood

18. On a scale of 1-7 (with 7 being very stressed) rate your general level stress. _____

19. Describe one situation you/participant parent handled well.

20. Rate stress level with child. _____

21. Describe one situation you/participant parent could have handled better.

Resource/Student parent report of Parent self care

Time _____ Day _____

Think back over the past 24 hours. Circle the number of the following self care behaviors that you observed/that you did.

BEHAVIOR	EXAMPLE
1. said something positive about self	_____
2. talked to a friend	_____
3. engaged in a positive/healthy activity	_____
4. got enough rest	_____
5. practiced stress reduction	_____
6. ate regularly and in a healthy way	_____
7. appropriately communicated	_____
upsetment or frustration	
8. asked for help when needed	_____
9. gathered information from community resource	_____
10. _____	_____

PARENT DAILY REPORT ON FIVE-YEAR-OLDS

(K. Kavanagh, OSLC, 1990)

Date _____ Time of Day _____

Child's Name _____ circle: Mom Dad

Following is a list of typical child behaviors. We are interested in your reports.
There are no right or wrong answers.

Please circle the number of each of the behaviors that occurred in the past 24 hours. If you made a response, please write your response. If you made no response, please write NR.

BEHAVIOR	PARENT RESPONSE
1. Talking back	_____
2. Being polite, showing good manners	_____
3. Not playing nicely with peers	_____
4. Being curious, asking questions	_____
5. Being dependent	_____
6. Not minding	_____
7. Playing alone	_____
8. Being considerate of others	_____
9. Observing or following standing rules	_____
10. Showing bad manners	_____
11. Hitting	_____
12. Sharing	_____
13. Going somewhere with permission	_____
14. Showing respect	_____
15. Not listening	_____
16. Physical or verbal meanness	_____
17. Expressing or communicating needs and feelings	_____

PARENT DAILY REPORT ON FIVE-YEAR-OLDS

BEHAVIOR	PARENT RESPONSE
18. Being affectionate	_____
19. Handling change or difficult situation	_____
20. Being destructive	_____
21. Being cooperative	_____
22. Listening	_____
23. Breaking a standing rule	_____
24. Yelling, screaming	_____
25. Being independent	_____
26. Name calling, rude talk	_____
27. Playing nicely with peers	_____
28. Minding	_____
ANY OTHER CHILD BEHAVIORS?	
29. _____	_____
30. _____	_____
31. _____	_____

APPENDIX C

Discussion Points for Legislators and Administrators

Why Shared Family Care?

- ◆ Fills a current service gap by providing an alternative to substitute care when in-home services may not be enough
- ◆ Helps break the cycle of inadequate parenting by allowing children to live with their families and have parents as models; children raised in institutional care are less likely to learn how to live in families or the appropriate role of parents
- ◆ Reduces emotional and financial costs of out-of-home placements
- ◆ Ultimately reduces costs of duplicated services (e.g., foster care for children and shelter or other residential facility for parent), and long-term services (e.g., long-term or repeated foster care, independent living, adoption)
- ◆ Instead of requiring substantial money to build new transitional homes or residences, it takes advantage of available space in homes of people who can benefit from the income, companionship, and/or opportunity to help others

Why Shared Family Care instead of intensive in-home preservation services?

- ◆ Provides opportunity for 24 hour supervision, interaction and observation in non-institutional environment and non-artificial situation, making it possible to determine the parent's commitment to parenting in a shorter period of time
- ◆ Provides natural training ground for parents in which mentors can respond to situations as they arise, rather than at specific set times
- ◆ Because of the mentors, it may be less staff-intensive
- ◆ Ensures 24-hour safety of child
- ◆ Provides parenting for individuals who often themselves were deprived of adequate parenting as children

Estimated Cost Comparisons

Because shared family care (SFC) is a new model in the United States, we do not yet know the minimum financial outlay necessary for its implementation. Nor do we know its full, long-term cost-saving potential. However, the following figures provide some estimates of how much it costs three programs to provide shared family care, and how these costs compare to the cost of serving children and families in other types of care.

Table 1 compares the estimated cost of shared family care with other types of in- and out-of-home care. Note, however, that the cost figures for out-of-home care and shared family care do not reflect the actual payment made for the care of a child. That is, they do not include the administrative costs or the supplemental payments that many states and counties offer care providers. Additionally, the costs of shared family care and in-home care include the expense of caring for a child and one parent; whereas the rates for out-of-home care estimate the expense of caring for only one child. They do not factor in the additional cost of caring for the parent, e.g., residential substance abuse treatment, which costs a national average of \$108 per day (Maryland Department of Human Resources, 1990). Nor do they consider repeated spells of out-of-home care (i.e., children re-entering foster care after unsuccessful reunification attempts) which occur for approximately one in five of these children. Similarly, the in-home cost estimates do not consider the fact that approximately 15 percent of children who receive intensive family preservation services eventually end up in out-of-home care. These factors should be considered in any comparative cost analysis of different categories of care. Finally, it is important to note the wide variance in rates among states and even within types of care (e.g., different rates based on age and special needs of child). This table may be more useful as a guide for local planners to use in presenting state or county specific information, than as a definitive source of cost data.

Table 2 compares the total cost of caring for one family (i.e., one child and one parent) in three different shared family care programs. These figures, however, do not necessarily reflect the minimum cost necessary to provide shared family care.

TABLE 1

ESTIMATED COST OF CARING FOR ONE CHILD			
Category of Care	Avg. Monthly Maintenance Cost per Child	Median Service Duration ¹	Avg. Total Maintenance Cost Per Child
OUT-OF-HOME CARE			
Basic Family Foster Care	\$362 ²	14 months	\$5,068
Treatment Foster Care	\$933 ³	14 months	\$13,062
Institutional Care	\$3,600 ⁴	13 months	\$46,800
SHARED FAMILY CARE	\$1,575 ⁵	4.75 months ⁶	\$7,481
IN-HOME CARE			
Intensive Family Preservation	\$2,800 ⁷	1.5 months	\$4,200
Conventional Supervision	\$233 ⁸	6 months	\$1,400

¹Information on median lengths of stay for the three types of out-of-home care are unpublished data from the University of California at Berkeley Foster Care Data Base.

²American Public Welfare Association, July 1995.

³Based on an average per diem maintenance rate of \$31.10 per child, Professional Association of Treatment Homes (PATH), St. Paul, MN, 1995. Note: there is an additional administrative cost of approximately \$20 per day (\$600 per month) for each child.

⁴Based on average daily maintenance rate of \$100 - \$140, Child Welfare League of America, 1994; Children's Bureau, DHHS, Washington, DC, 1994.

⁵Based on an average of *A New Life* Program's basic 1995 maintenance rate of \$43/day or \$1,290/month for a single parent with one child, and Minnesota Human Service Associates' basic 1995 rate of \$62/day or \$1,860/month for a single parent with one child. Note: HSA has an additional administrative cost of approximately \$36/day (\$1,080/month) for each parent/child dyad, and *A New Life* Program's additional administrative cost is approximately \$45/day (1,350/month) (see Table 2).

⁶An average of the median lengths of stay in *A New Life* Program and Minnesota Human Service Associates' *Whole Family Placement Program*.

⁷Based on a family with one child. (Note: the average cost of services for a family with two children is estimated to be \$3,400.) Yuan, Y.-Y. (1990). "Cost analysis." In Y.-Y.T. Yuan and M. Rivest (eds.). *Preserving families: Evaluation resources for practitioners and policy makers*. Newbury Park, CA: Sage Publications.

⁸Based on cost of salary, benefits, supervision and overhead for an in-home family maintenance social worker (\$84,000) carrying 30 cases at a time for six months.

TABLE 2

TOTAL AVERAGE COST OF THREE FAMILY CARE MODELS					
Program	Avg. Monthly Maintenance Rate ¹	Avg. Monthly Admin. Cost	Avg. Total Monthly Cost per Family	Medium Service Duration	Total Avg. Cost per Family
A New Life	\$1,290	\$1,350	\$2,640	3.5 months ²	\$ 9,240
HSA	\$1,860	\$1,080	\$2,940	6 months	\$17,640
CH&ASI	\$1,114 ³	\$1,114	\$2,280	18 months ⁴	\$41,040

¹A family is considered one parent with one infant or young child. The maintenance rate for *A New Life* Program is the same regardless of the size of the client family (although most are only a parent/child dyad); whereas the HSA program determines the maintenance rate per individual (i.e., their per diem maintenance rate is approximately \$31 per individual in care, so the monthly maintenance rate for a mother with two children would be \$2,790 vs. \$1,860 for a mother/child dyad). Also, eligible families in *A New Life* Program continue to receive AFDC and food stamps, which they are expected to use to purchase food and other necessities. Conversely, clients in HSA's program do not receive AFDC or food stamps while in placement, so the monthly maintenance payment is expected to cover these expenses.

²3.5 months is the average length of stay in mentor homes. However, this is just one component of a long-term, comprehensive substance abuse treatment program for women. After leaving the mentor home, most clients in *A New Life* Program move onto transitional housing and continue to participate in the treatment and recovery program at *A New Life*.

³Maintenance funds are used to provide each teen mom with a \$28 monthly allowance, a \$88/month bus pass, \$25/month for hygiene and \$72/month for clothing.

⁴This median service duration includes one family who stayed in placement for 44 months and one who stayed for only one day. Without these two extremes, the median duration is 19 months.

APPENDIX D

Evaluation Instruments

Overall Family Assessment

- *The Family Risk Scales* (1987), Magura, S., Moses, B.S. & Jones, M.A.: Child Welfare League of America (Washington, DC)
- *Family Assessment Measure* (FAM) (1984), Skinner, H.A., Steinhauer, P.D. & Santa-Barbara, J.: FAM Project (Toronto, Canada)
- *Family Environment Scales* (FES) (1981), Moos, R.H. & Moos, B.S.: Consulting Psychologists Press (Palo Alto, CA)
- *Focus on Families* (FOF), Catalano, R.F.: University of Washington, School of Social Work (Seattle, WA). Note: family management for parents with children aged 3-14.
- *Raising Healthy Children*, Catalano, R.F.: University of Washington, School of Social Work (Seattle, WA). Note: Interview with parent of children under 11 years old.
- *Child Abuse Potential Inventory* (1986), Milner, J.S.: Psytec Corporation (Webster, NC)
- *Child Well-Being Scales* (1986), Magura, S. & Moses, B.S.: Child Welfare League of America (Washington, DC)
- *Systematic Decision Making*, IOX Assessment Associates (Culver City, CA)
- *HOME Observation for Measurement of the Environment* (1984). Caldwell, B.M., Bradley, R.H.: University of Arkansas (Little Rock, AR). Note: for families with children 0-12 years old

Parenting Ability

- ◆ *Parenting Stress Index* (1986), Abidin, R.R.: Pediatric Psychology Press (Charlottesville, VA)
- ◆ *Greenspan-Lieberman Observation System for Assessment of Caregiver-Infant Interaction during Semi-Structured Play (GLOS)* (1983), Greenspan, S., Lieberman, A. & Poisson, S.: Regional Center for Infants and Young Children (Rockville, MD)
- ◆ *Maternal Behavior Rating Scale Subscales* (1985), Mahoney, G.: Pediatric Research and Training Center (Farmington, CT)
- ◆ *Parent Behavior Progression* (1983), Bromwich, R.: Department of Educational Psychology and Counseling, California State University (Northridge, CA)
- ◆ *Parent/Caregiver Involvement Scale* (1986), Farran, D., Kasari, C., Comfort, M & Jay, S.: Continuing Education, University of North Carolina (Greensboro, NC)
- ◆ *Parent-Child Early Relational Assessment* (1985), Clark, R.: Department of Psychiatry, University of Wisconsin Medical School (Madison, WI)
- ◆ *Conflict/Interaction Behavior Questionnaire* (1988), Robin, A. & Foster, S.: Pergamon (New York, NY)

Resources and Social Support

- ◆ *Questionnaire on Resources and Stress*, Long Form (1974), Holroyd, J.; Short Form (1983), Friedrich, W.N., Greenberg, M.T. & Crnic, K.A.: University of California School of Medicine (Los Angeles, CA)
- ◆ *Family Inventory of Resources for Management* (1981), McCubbin, H., Patterson, J., Millar, R. & Millar, A.: University of Minnesota (St. Paul, MN)
- ◆ *Community Life Skills Scale* (1988), Barnard: Nursing Child Assessment Satellite Training, University of Washington (Seattle, WA)
- ◆ *Daily Stress Inventory* (1991), Brantley, P. & Jones, G.
- ◆ *Network Viability Inventory* (1984), Nicolaidis, M. & Sica, M.
- ◆ *Family Needs Survey* (1988), Bailey, D.B. & Simeonsson, R.J.: Frank Porter Graham Child Development Center, University of North Carolina (Chapel Hill, NC)

- ◆ *Family Resource Scale* (1988), Leet, H.E. & Dunst, C.J.: Family, Infant & Preschool Program, Western Carolina Center (Morganton, NC)
- ◆ *Family Support Scale* (1988), Dunst, C.J., Jenkins, V. & Trivette, C.M.: Family, Infant & Preschool Program, Western Carolina Center (Morganton, NC)

Parental Psychosocial and Emotional Well-Being

- ◆ *Beck Depression Inventory* (1961), Beck, A.T., Ward, C., Mendelson, M., Mock, J., & Erbaugh, J.: The Psychological Corporation, (San Antonio, TX)
- ◆ *California Psychological Inventory* (1987), Gough, H.G.: Consulting Psychologists Press (Palo Alto, CA). Note: self-administered
- ◆ *Clinical Measurement Package (CMP)* (1982), Hudson, W.W.: The Dorsey Press (Homewood, IL)
- ◆ *Maternal Self-Report Inventory* (1988), Shea and Tonick

Substance Abuse

- ◆ *Drug Use Checklist*, Cook, R.F.: Institute for Social Analysis (Reston, VA). Note: self-administered
- ◆ *CAGE Alcohol Use Index*
- ◆ *Addiction Severity Index* (1988), McLellan, T.A. et al.: Veterans Administration Medical Center (Philadelphia, PA)

Infant/Child Development

- ◆ *Bayley Scales of Infant Development* (1969), Bayley, N.: The Psychological Corporation, (New York, NY)
- ◆ *Minnesota Child Development Inventories* (1974), Ireton, H. & Thwing, E.: University of Minnesota Medical Center (Minneapolis, MN). Note: Parents complete after observing 6 month to 6 year old child.
- ◆ *Denver Developmental Screening Test II* (1975), Frankenburg et al.: Denver Developmental Materials (Denver, CO). Note: for children 0-6 years old.

- ◆ *Scales of Infant Psychological Development* (1975), Uzgis, I. & Hunt, J.McV.: University of Illinois Press (Urbana, IL)
- ◆ *Play Assessment Checklist for Infants* (1981), Bromwich, R.M.: California State University Department of Educational Psychology and Counseling (Northridge, CA)
- ◆ *Child Behavior Checklist* (1986), Achenback, T. : Center for Children, Youth and Families, University of Vermont (Burlington, VT). Note: parent rates children ages 4-16 years old.
- ◆ *Vineland Adaptive Behavior Scales* (1984), Sparrow, S. et al.: American Guidance Service, Inc. (Circle Pines, MN)
- ◆ *Infant Behavior Questionnaire* (1978), Rothbart, M.K.: University of Oregon, Department of Psychology (Eugene, OR)

Family Satisfaction with Services

- ◆ *Parent Outcome Interview* (1986), Magura, S. and Moses, B.S.: Child Welfare League of America (Washington, DC)
- ◆ *Client Satisfaction Inventory* (1982), DeLoayza, W. & Salsberg, L.S.